Request For Proposals
For
MENTAL HEALTH SERVICES FOR CHILDREN IN RATE CLASSIFICATION LEVEL (RCL) – 14 PLACEMENTS

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RFP DBH – 05 – 79

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I. INTRODUCTION

A. Purpose

The County of San Bernardino Department of Behavioral Health (DBH), hereafter referred to as "County" or "DBH", is seeking proposals from interested and qualified organizations and agencies to provide mental health Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children who are San Bernardino County Medi-Cal beneficiaries placed in RCL-14 residential care settings.

Specific services to be provided under this Request for Proposals (RFP) are outlined under Section IV, Program Requirements. Proposals are to be submitted for one year (the anticipated Contract period of August 1, 2006 through July 31, 2007). The DBH may, but is not obligated to, extend awarded contract(s) for up to two (2) additional one-year periods contingent on the availability of funds and Vendor(s) performance. The number of awards will be determined by the number and quality of the proposals received.

B. Minimum Proposer Requirements

Proposers must:

1. Be a nonprofit or other legally constituted business entity.
2. Have no record of unsatisfactory performance. Proposers who are or have been seriously deficient in current or recent contract performance, in the absence of circumstances properly beyond the control of the Proposer, shall be presumed to be unable to meet this requirement.
3. Have the ability to maintain adequate files and records and meet statistical reporting requirements.
4. Have the administrative and fiscal capability to provide and manage the proposed services and to ensure an adequate audit trail.
5. Have a current Medi-Cal certification or have to the ability to become Medi-Cal certified.
6. Meet all presentation and participation requirements listed in this RFP.
7. Have a representative at the mandatory proposal conference as referenced in this RFP.

C. Mandatory Proposal Conference

A mandatory Proposal Conference will be held at **1:00 p.m.** on May 31, 2006 at:

The County of San Bernardino
Department of Behavioral health
Behavioral Health Resource Center – Auditorium
850 E. Foothill Blvd
Rialto, CA 92376

Attendance at the Proposal Conference is mandatory. No proposal will be accepted from any Proposer who fails to attend the Proposal Conference.

D. Correspondence

All correspondence, including proposals, is to be submitted to:

County of San Bernardino
Department of Behavioral Health
Contract Unit (RFP DBH 05 – 79)
700 East Gilbert Street, Bldg 3
San Bernardino, CA 92415-0920

Johnnetta Gibson, Staff Analyst II
Phone: (909) 387-7747
E-mail: jgibson@dbh.sbcounty.gov

During the proposal and evaluation process, the individual identified above is the sole contact point for any inquiries or information relating to this RFP. Only if authorized by the County's contact may other County Staff provide information. Any violation of this procedure may be grounds for disqualification of the Proposer. It is the responsibility of the Proposer to ensure that the RFP response arrives in a timely manner.

E. Proposal Submission Deadline

All proposals must be received at the address listed in Paragraph D of this Section no later than 4:00 p.m. on June 20, 2006. Facsimile or electronically transmitted proposals will not be accepted since they do not contain original signatures. Postmarks will not be accepted in lieu of actual receipt. Late proposals will not be considered**.**

II. PROCUREMENT TIMELINE

Proposal Conference	May 31, 2006
Deadline for submission of questions	**June 6, 2006** ****Questions may be submitted in writing prior to the Proposal Conference.**
Deadline for submission of proposals	June 20, 2006 at 4 pm
Tentative date for mailing award/denial Letters	July 6, 2006
Tentative Deadline for protests	July 13, 2006
Tentative date for awarding of Contract(s)	July 25, 2006
Tentative Start Date for Contract(s)	August 1, 2006

THE ABOVE DATES ARE SUBJECT TO CHANGE IF DEEMED NECESSARY BY THE DBH.

III. PROPOSAL CONDITIONS

A. Contingencies

Funding for this program is contingent upon State and Federal funding. Compensation for this program is contingent on adherence to Medi-Cal standards for reimbursement. This RFP does not commit the County to award a Contract. The County realizes that conditions other than cost are important and will award Contract(s) based on the proposal that best meets the needs of the County.

The County reserves the right to accept or reject any or all proposals if the County determines it is in the best interest of the County to do so. The County will notify all Proposers, in writing, if the County rejects all proposals.

B. Modifications

The County has the right to issue addenda or amendments to this RFP. The County also reserves the right to terminate this procurement process at any time.

C. Proposal Submission

To be considered, all proposals must be submitted in the manner set forth in this proposal. **It is the Proposer's responsibility to ensure that its proposal arrives at proper address on or before the specified time.** All proposals and materials submitted become the property of the County.

D. Public Inspection

Proposals will be maintained as confidential until issuance of contracts to selected Vendor(s). At that time proposals submitted in response to this RFP become the property of the County of San Bernardino and are subject to the provisions of the California Public Records Act. This Act is designed to give reasonable public access to information in the possession of public agencies.

E. Inaccuracies or Misrepresentations

If in the course of the RFP process or in the administration of a resulting Contract, the County determines that the Proposer has made a material misstatement or misrepresentation or that materially inaccurate information has been provided to the County, the Proposer may be terminated from the RFP process, or in the event a Contract has been awarded, the Contract may be immediately terminated.

In the event of a termination under this provision, the County is entitled to pursue any available legal remedies.

F. Incurred Costs

This RFP does not commit the County to pay any costs incurred in the preparation of a proposal in response to this request and Proposer agrees that all costs incurred in developing this proposal are the Proposer's responsibility.

G. Negotiations

The County may require the potential Vendor(s) selected to participate in negotiations, and to submit revisions to pricing, technical information, and/or other items from their proposal(s) as may result from these negotiations.

H. Independent Contractor

Any Proposer that is awarded a contract will be considered an independent Vendor(s), wholly responsible for the manner in which it performs, and will assume exclusively the responsibility for the acts of its employees who will not be entitled to any rights and privileges of County employees nor be considered in any manner to be County employees.

I. Level of Service

For any Contract awarded as a result of the RFP, no minimum or maximum number of client referrals can be guaranteed by the County.

J. Termination of Awarded Contract

The Contract between the County and selected Vendor(s) will contain specific language which addresses the option of both the selected Vendor(s) or County to terminate the Contract without cause, termination for the convenience of the County, and termination for cause.

IV. PROGRAM REQUIREMENTS

A. Definitions

1. **Assembly Bill (AB) 2726** – AB 2726, chaptered in 1996, establishes the provision of mental health services concerning referrals of pupils for services and the responsibilities of the participating entities.

2. **Community-Based** – The concept of children and families receiving formal services, whenever possible, in the community where they live. This will enable them to live, learn, and grow safely, competently, and productively in their families, neighborhoods, and natural environment.

3. **Cost Effectiveness** – Achieving the desired goal with a minimum of expenditure.

4. **Crisis** – An unplanned event that results in the individual's need for immediate service intervention.

5. **Cultural Relevance (Cultural Competency)** – The acceptance and understanding of cultural mores and their possible influence on the client's issues and/or behavior, i.e., using the understanding of the differences between the prevailing social culture and that of the client's family to aid in developing individualized supports and services.

6. **Department of Behavioral Health (DBH)** – The Department of Behavioral Health (DBH), under state law, provides mental health treatment and prevention services to County residents. In order to maintain a continuum of care, DBH operates or, contracts for the provision of, 24-hour care, day treatment, outpatient services, case management, and crisis and referral services. Community services are provided in all major County metropolitan areas and are readily accessible to County residents. Additionally, DBH assists individuals utilizing a wellness, Recovery/Discovery approach to help the individual to live a healthy, satisfying, and hopeful life, despite limitations and/or continuing effects caused by his/her mental illness and/or substance abuse, in the least restrictive setting possible.

7. **Department of Children's Services (DCS)** – DCS provides family-centered programs and services designed to ensure safe, permanent, nurturing families for the County's children while strengthening and attempting to preserve the family unit.

8. **Department of Public Health (DPH)** – DPH provides a foundation for the success for each child by giving him/her the highest quality child development and family support services while offering community and preventive health services that promote and improve the health, safety, well being, and quality of life in the County.

9. **Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT Medi-Cal)** – A federally mandated Medicaid option that requires states to provide screening, diagnostic and treatment services to persons under age 21 who have unrestricted Medi-Cal and also meet necessary medical criteria by having a qualifying mental health diagnosis and functional impairment that is not responsive to treatment by a "healthcare-based" provider. In addition, services are generally acceptable for the purpose of correcting or ameliorating the mental disorder. For the purposes of this proposal, EPSDT Medi-Cal Rehabilitative Mental Health Services activities may include: Assessment, Collateral, Crisis Intervention, Evaluation, Medication Support Services, Plan Development, Rehabilitation and Therapy.

    a. **Assessment** – The examination designed to provide formal documented evaluation or analysis of the cause or nature of the patient's mental, emotional, or behavioral disorder. Assessment services are limited to an intake examination, mental health evaluation, physical examination, and laboratory testing necessary for the evaluation and treatment of the patient's mental health needs. Relevant cultural issues and history should be included where appropriate.

    b. **Collateral** – Contacts with one or more significant support persons in the life of the individual which may include consultation and training to assist in better utilization of services and understanding of mental illness; services include, but are not limited to, helping significant support persons to understand and accept the individual's condition and involving them in

service planning and implementation of the service plan(s). Family counseling or therapy that is provided on behalf of the individual is also considered collateral.

c. **Crisis Intervention** – A rapid emergency response service enabling the individual to cope with a crisis, while maintaining his/her status as a functioning community member, and is limited to stabilization of the presenting emergency. This service does not include Crisis Stabilization, which is provided in a 24-hour health care facility or hospital outpatient program. Service activities include but are not limited to Assessment, Evaluation, Collateral and Therapy (all billed as crisis intervention).

d. **Evaluation** – An appraisal of the client's developmental, social, emotional, and behavioral functioning in several areas including living situation, daily activities, social support systems, and health status. Cultural issues are to be addressed where appropriate.

e. **Medication Support Services** – Includes the prescribing, administering, dispensing, and monitoring of psychiatric medications to alleviate the symptoms of mental illness which are provided by a staff person, within the scope of his/her profession. This service includes the evaluation of the need for medication, clinical effectiveness, and side effects of medication, obtaining informed consent or court order, medication education, and plan development related to the delivery of these services.

f. **Plan Development** - The development of treatment or service plans and the monitoring of the individual's progress.

g. **Rehabilitation** – This is a service activity that may include any or all of the following:

(1) Assistance in restoring or maintaining an individual's or group of individual's functional skills, daily living skills, social skills, grooming, personal hygiene skills, meal preparation skills, medication compliance, and support resources.

(2) Counseling of the individual and/or family.

(3) Training in leisure activities needed to achieve the individual's goals/desired results/personal milestones.

(4) Medication education.

h. **Therapeutic Behavioral Service (TBS)** – An intensive, one-on-one, face-to-face, short-term outpatient treatment intervention, authorized for a specified period of time, designed to maintain the child/adolescent's residential placement at the lowest appropriate level by resolving

targeted behaviors and achieving short-term treatment goals. To qualify for EPSDT Medi-Cal reimbursement for this service, a child/youth must meet criteria in sections 1, 2 and 3 below.

(1) Eligibility for TBS - must meet criteria a. and b.

(a) Full-scope Medi-Cal beneficiary under age 21 years.

(b) Meets Mental Health Plan (MHP) medical necessity criteria.

(2) Must meet criteria a., b., c. or d.

(a) Child is placed in a group home facility of RCL 12 or above or a locked treatment facility

(b) Child is being considered for a facility described above

(c) Child has had at least one emergency psychiatric hospitalization related to his/her current presenting disability within the preceding 24 months

(d) Child has previously received TBS while a member of the class.

(3) Demonstrate a need for TBS, - must meet criteria (a) and (b)

(a) The child is receiving other specialty mental health services.

(b) After clinical assessment it is determined that without the additional short-term support of TBS, the child will:

(i) Need to be placed at a higher level of care; or

(ii) Not be able to transition to lower level of care.

i. **Therapy** - A service activity that may be delivered to an individual or group of individuals and may include family therapy (when the individual is present). Therapeutic interventions are consistent with the individual's goals, desired results, and personal milestones and focus primarily on symptom reduction as the means to improve functional impairments.

10. **Evidence based** – A treatment approach based on research which has shown that by learning more about managing mental illness, individuals who have experienced psychiatric symptoms can take important steps toward recovery. This includes learning about the individual's mental illness and strategies for treatment, decreasing distress from symptoms, reducing relapses and rehospitalizations, use of medications more effectively and making progress towards goals and recovery. Also included are interventions for which there is

consistent, scientific evidence showing that they improve outcomes for consumers.

11. **Family-centered** – The needs of children are addressed in the context of their families. Parents or other persons who are the primary or natural caregivers for the children participate in all aspects of the development and implementation of the plan of support and services, to the degree they are able, and to the extent permitted by any outstanding orders of the court.

12. **Family Setting/Types** – Any family setting where there is a relative or caregiver interested in strength-based services and willing to work toward permanency. This may include parents, relative placements, guardianships, and/or foster homes.

13. **Formal/Professional Resources, Services, and Supports** – Traditional social service options administered by professionals, e.g., counseling, psychological evaluations, parenting classes, and anger management training.

14. **Foster Care** – Foster care is a temporary placement, which assists children in preparing for return to their birth parents or for an alternate permanent placement. Social workers visit the home on a regular basis to provide services to support the children's needs. Foster parents receive ongoing financial and medical assistance.

15. **Full-Time Equivalent (FTE)** – The percentage of time a staff member works, represented as a decimal. A full-time person is 1.00, a half-time person is .50 and a quarter-time person is .25.

16. **Interagency Placement Counsel (IPC)** – A committee made up of members of DBH, Probation, DCS and other partnering agencies. Members are responsible for screening and assessing initial referrals for children in need of placement in RCL 11 and above. IPC ensures the assessment and recommendation will result in the special needs of the child being met.

17. **Individualized Service Plan (ISP)** – A flexible, creative approach to plan of care/treatment for clients based on assessment of needs, resources, and family strengths with the ultimate goal of promoting the self-sufficiency of the family in dealing with their unique challenges. The plan reflects the best possible fit with the culture, values, and beliefs of the client and family/caregiver(s) and the referring agency's safety concerns.

18. **Inland Regional Center (IRC)** – IRC is an agency, contracted through the California Department of Developmental Services, which provides services to children and adults diagnosed with autism, mental retardation, and cerebral palsy.

19. **Medical Necessity** – The client must meet criteria outlined in (a), (b), and (c) below to be eligible for services:

a. Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Latest Edition, published by the American Psychiatric Association:

(1) Pervasive Developmental Disorders, except Autistic Disorders

(2) Disruptive Behavior and Attention Deficit Disorders

(3) Feeding and Eating Disorders of Infancy and Early Childhood

(4) Elimination Disorders

(5) Other Disorders of Infancy, Childhood, or Adolescence

(6) Schizophrenia and other Psychotic Disorders

(7) Mood Disorders

(8) Anxiety Disorders

(9) Somatoform Disorders

(10) Factitious Disorders

(11) Dissociative Disorders

(12) Paraphilias

(13) Gender Identity Disorder

(14) Eating Disorders

(15) Impulse Control Disorders Not Elsewhere Classified

(16) Adjustment Disorders

(17) Personality Disorders, excluding Antisocial Personality Disorder

(18) Medication-Induced Movement Disorders related to other included diagnoses

b. Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (a) above:

(1) A significant impairment in an important area of life functioning.

(2) A probability of significant deterioration in an important area of life functioning.

(3) Except as provided in Title 9, California Code of Regulations (CCR), Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.

c. Must meet each of the intervention criteria listed below:

(1) The focus of the proposed intervention is to address the condition identified in (b) above.

(2) The expectation is that the proposed intervention will:

(a) Significantly diminish the impairment, or

(b) Prevent significant deterioration in an important area of life functioning, or

(c) Except as provided in Title 9, CCR, Section 1830.210, allow the child to progress developmentally as individually appropriate.

(3) The condition would not be responsive to physical health care based treatment.

20. **Memorandum of Understanding (MOU)** – An official statement outlining a mutual understanding between parties as to their working relationships.

21. **Promising Practice** – The practice of using clinical or administrative practices for which considerable supporting scientific evidence exist and which show promise for improving client outcomes, but which have not yet been tested under the most rigorous form of scientific inquiry – that is, multiple randomized controlled trials.

22. **Rate Classification Level (RCL)** – A system used by the State of California, Department of Social Services, Community Care Licensing Division in which group home providers are classified, or licensed, according to the level of care and services provided. The RCL process uses a point system to measure the level or intensity of care and supervision. Points are based on the number of hours per child per month of services provided in the following three components: Child Care and Supervision, Social Work Activities, and Mental Health Treatment Services.

23. **Request for Proposals (RFP)** - The document used to solicit a solution or solutions from potential Vendor(s) to a specific problem or need. Although price is important, effectiveness of the proposal and the background and experience of the Proposer are evaluated in addition to the proposed price.

24. **Schedule of Maximum Allowances (SMA)** – SMA refers to regulating maximum amounts payable by function for medical and related services pursuant to Welfare and Institutions (W& I) Code 5720 (a) and (b).

25. **Wraparound Services** – A family-centered, strengths-based, needs-driven planning process for creating individualized services and supports for children and their families. This process facilitates access to natural, professional and community-based options, activities and opportunities. It allows children to return to, or continue living in, a family setting rather than in an RCL 10 –14 group home.

B. Reference Documents

The DBH contracts unit has copies of the following materials available for review:

1. W& I Code Section 5328
2. Title 9, Division 4, California Code of Regulations (CCR) Sections 9000 et seq
3. Applicable provisions of Title 22, CCR
4. 42 Code of Federal Regulations (CFR), part 2
5. Health and Safety (H&S) Code Section 11812
6. (H&S) Code Section 11878
7. (H&S) Code Section 11977
8. W& I Code Section 14100.2
9. Title 22, CCR Section 51009
10. Clean Air Act (42 United States Code 7603)
11. Americans with Disabilities Act
12. Executive Orders 11246, as amended by Executive Order 11375, 11625, 11738, 12138, 12432, 12250
13. Title VII of the Civil Rights Act of 1964
14. Office of Management and Budget Circulars A-133
15. State Department of Mental Health (DMH) Letter NO.: 98-02
16. DBH Treatment Authorization Procedures for TBS
17. DBH Treatment Authorization Procedures for Day Treatment / Day Rehabilitative services.
18. Definitions of Rehabilitative Services Activities.

Copies of these materials are available for review by appointment only, Monday through Thursday from 8:00 a.m. to 4:00 p.m. at the DBH Contracts Unit office.

C. Background and Program Description

DBH, the County's Medi-Cal Mental Health Plan (MHP), and its behavioral health services contractors provide mental health treatment services throughout San Bernardino County. County departments, including DCS, Probation, and DBH, are responsible for meeting the residential treatment needs of minors in their care. Many of these minors need specialized residential treatment services, as ordered by the Juvenile Court or required by the Education Code, in State licensed group homes.

As has been the case historically, some children within San Bernardino County will need out-of-home residential placement in a supervised environment. The County has identified a need for ways to improve mental health services delivery to San Bernardino County's children in RCL-14 placements.

In order to provide children the intensity of services they require, minors are sometimes placed in costly inpatient hospital or out-of-area long-term residential care settings due to the lack of appropriate level placements in the local community. San Bernardino County child-placing agencies must sometimes over utilize inpatient hospitals while minors await more appropriate placements or place minors in available beds at levels of residential care which may not have a sufficient array of interventions and/or treatment. Proposers shall be licensed at a minimum of a RCL–12 through RCL–14. DBH will be funding the mental health portion of this program through the EPSDT program.

D. Program Scope of Services

The target population is Medi-Cal eligible and AB 2726 authorized children and youth between the ages of 10 and 18 who will need RCL–14 residential placement, and who have been identified and authorized by the IPC as children who are having behavioral health problems and who meet Medical Necessity for Specialty Mental Health Services (W&I Code 5600.3.). The selected Vendor(s) will provide services to all children meeting medical necessity criteria as defined by DBH and State and Federal regulations and are further defined by DBH's Systems of Periods of Allowable Treatment for Psychotherapy and Rehab/DL (Attachment A) and DBH's Outpatient Practice Guidelines (Attachment B). The population's problems are caused by or due to a mental health disorder and may interfere with their academic performance or functioning in their family, school or community settings. These problems put them at risk for a higher level of mental health care and out-of-home placement.

Selected Vendor(s) will work cooperatively within the San Bernardino County residential system of care, including other placement agencies, Wraparound, Therapeutic Behavioral Services (TBS), parent/consumer partnerships and other mental health services. The County supports collaboration of the agencies serving children and families and recognizes parents and families as full partners. Selected Vendor(s) shall strive to make community-based and individualized services available to the children and families it serves.

The Group Home shall be located within San Bernardino County. The program is expected to focus on the children's strengths, provide both therapy and a strong therapeutic milieu where children can diminish or eliminate emotional and behavioral problems, and teach living skills to prevent long-term hospitalization, allowing the children to return home or to a less restrictive community setting, preferably within **90 days** or less of admission to the program, unless the case has been approved by DCS and DBH.

Children referred to this program will have a severe mental health disorder and will have had multiple prior placements, a history of runaways, and may be resistant to placement in the program. They are expected to have behaviors such as being resistant to authority and refusing to follow rules, destroying property, being physically assaultive, setting fires, acting out sexually, being suicidal, self-harming,

using drugs or alcohol, being verbally assaultive, being psychotic, may have borderline or below borderline intelligence, and are often delayed in school.

The County encourages the utilization of Evidenced Based and Promising Practices. These therapies provide better outcomes for youth who are challenged with severe mental illness. The DBH also encourages the selected Vendor(s) to train their staff in Drug and Alcohol education and treatment, Aggression Replacement Therapy (ART), Cognitive Behavioral Therapy, Gender specific therapy and others identified in the research literature provided by the California Mental Health Planning Council.

1. Priority population will be adolescents with co-occurring disorders which includes mental health disorders and substance abuse problems.

   Specific services to be provided include:

   a. Residential Program Component

      The RCL–14 (Residential Program Component) will be expected to be maintained, at a minimum, within the standardized classification point level requirements for an RCL–14 as described by the California State Department of Social Services (CDSS) Foster Care Program Bureau. Also, the awarded selected Vendor(s) will be expected to fulfill all Community Care Licensing Division regulations and requirements in regards to the operation of the RCL-14 group home. The monitoring of the Residential Program Component will be conducted by the appropriate County and State agencies. However, DBH will monitor the provision of mental health services and the RCL 14 certification in accordance with State DMH letter 98-02.

   b. Mental Health Services Component

      Wellness and Discovery is an approach to helping the individual to live a healthy, satisfying and hopeful life despite limitations and/or continuing effects caused by his or her mental illness. Rehabilitation is a strength-based approach to skills development that focuses on maximizing an individual's functioning. Services will support the individual in accomplishing his/her desired results.

      It is believed that all clients can recover, even if that recovery is not complete. The Recovery, Wellness and Discovery approach involves collaborating with the client to facilitate hope and empowerment with the goals of counteracting internal and external stigma, improving self-esteem, encouraging client self-management of his/her life, including making his/her own choices and decisions, re-integrating the client back into his/her community as a contributing member, and achieving a satisfying and fulfilling life.

      (1) Selected Vendor(s) must have licensed clinical staff, (Psychologist, MFT, or LCSW) or those who are waivered, to do

individual, group and family therapy as required by an individualized treatment plan. State law requires that doctoral-level psychologists employed by public agencies for licensure (including DBH contract agencies), who are not yet licensed but are preparing for licensure, must receive a waiver to practice from the State Department of Mental Health. In order to receive reimbursement from the State for mental health services, all pre-licensed clinical therapists must be registered with the State Board of Behavioral Science Examiners (BBSE), or waivered by the State in the case of certain license-eligible out-of-state applicants. The selected Vendor(s) will comply with DBH standard practice policies.

(2) Selected Vendor(s) must have a licensed psychiatrist for medication evaluation, prescription and consultation as part of the treatment team. The psychiatrist will meet regularly with the treatment team and be available as needed for services to the clients.

(3) In order for the selected Vendor(s) to be eligible for reimbursement of TBS services through EPSDT Medi-Cal, clients must meet medical necessity criteria for this service as specified in Article IV Program Requirements, A. Definitions, h. Therapeutic Behavioral Service. If an agency than the residential provider provides such services (TBS coaches), full staff cooperation with the coaching process and the coach's recommendations are to be documented in the client's file as a part of the treatment planning.

(4) Selected Vendor(s) must have a location that is accessible by public transportation, approved by DBH and consistent with ADA requirements.

(5) Selected Vendor(s) must be Medi-Cal certified.

(6) Selected Vendor(s) will be required to comply with all State regulations regarding State Performance Outcome measurement requirements, and participate in the outcome measurement process as required by the State and/or DBH.

(7) The DBH Research and Evaluation Section (R&E) will collect important outcome information from targeted consumer groups and selected Vendor(s) throughout the term or any contract awarded. R&E will notify the selected Vendor(s) when its participation is required. The performance outcome measurement process will not be limited to survey instructions but will also include, as appropriate, client and staff interviews, chart reviews, and other methods of obtaining information needed.

(8) DBH strongly encourages utilization of evidence-based or promising practices.

(9) DMH mandates counties to develop and implement a Cultural Competency Plan for Medi-Cal beneficiaries. Policies and procedures and the array of services provided must be culturally and linguistically appropriate. Selected Vendor(s) will be included in the implementation process and shall adhere to cultural competency requirements. Selected Vendor(s) will have a cultural competency plan in place for the facility and a training plan for staff. The staff demographics should reflect the clients being served.

(10) The selected Vendor(s) will make a documented effort to gather demographic information on its service area for service planning.

(11) Selected Vendor(s) shall allow DBH staff access to clients' records.

(12) Selected Vendor(s) shall provide periodic program reports, as required. Selected Vendor(s) shall cooperate with DBH staff in all matters related to the monitoring of the programs to include annual program reviews and medical record audits.

(13) Selected Vendor(s) must maintain records according to DBH standards and keep them on file for seven (7) years following discharge or last date of service.

(14) Selected Vendor(s) must operate under all County Treatment Authorization Procedures.

c. Additional Service Requirements

Both the Residential and the Mental Health Services Program Component will be expected to provide an appropriate therapeutic milieu where children can diminish or eliminate emotional and behavioral problems and which will teach living skills to prevent transfer to higher RCL categories of care or long-term hospitalization. This allow the children to return home or to a less restrictive community setting, preferably within six months of admission to the program. The selected Vendor(s) should be able to demonstrate that they have staff who are capable of working with youth who are challenged with drug and alcohol problems as well as mental health problems, and who possess the skills necessary to manage daily and weekly crisis.

The desired program will have the following components:

(1) The selected Vendor(s) shall maintain facilities and equipment and operate continuously with the minimum number and

classification of staff required for the provision of services in accordance with the W&I Code and Title 9 of the CCR.

(2) Selected Vendor(s) shall coordinate and collaborate with DBH staff, San Bernardino County child-placement agencies and other agency partners.

(3) The program is expected to cooperate fully with DBH/DCS/Probation personnel. Program staff may be required to attend meetings away from the residence(s). Case managers, social workers, and quality assurance personnel will be allowed access to clients, facilities, records and staff as necessary at any time.

(4) Selected Vendor(s) should have access to nursing services in order to care for clients admitted with medical issues requiring nursing care.

(5) Nocturnal (NOC) shift should either have 2 staff members on at all times, or a supervisory staff person who makes unscheduled, unannounced visits during the night to ensure that staff are awake and clients are safe.

(6) The intake coordinator will be a licensed mental health professional. Selected Vendor(s) will respond to referrals for placement within five working days unless it is a crisis situation. If a case is determined to be a crisis situation by either DCS or DBH, the selected Vendor(s) will work with the agencies to place the child as soon as possible.

(7) The selected Vendor(s) personnel will possess appropriate licenses and/or certificates and be qualified in accordance with applicable statutes and regulations. The selected Vendor(s) will obtain, maintain and comply with all necessary government authorizations, permits and licenses required to conduct its operations. In addition, the selected Vendor(s) will comply with all applicable Federal, State and local laws, rules, regulations and orders in its operations including compliance with all applicable safety and health requirements as to the Vendor(s) employees.

(8) All staff should be trained in recognizing warning signs of physical, emotional, and sexual child abuse and neglect, and in recognizing predatory behavior by clients, persons in the community, and persons on staff. All staff should know and follow child abuse reporting requirements and Special Incident Reporting requirements as required by law.

(9) The treatment milieu shall include a focus on ethnic, cultural, and gender differences and similarities. All staff must attend quarterly training that includes culturally competent treatment strategies which are incorporated into their interactions with clients and staff.

The program shall maintain training sign-in sheets, which can be requested by the County.

(10) Selected Vendor(s) will make available opportunities for the practice of religious or spiritual beliefs. Questions about religious and spiritual practices should be routinely asked of the clients and recorded in their case file.

(11) Selected Vendor(s) will provide a strong substance abuse awareness program. When required by specific clients, clinicians will be able to address specific addiction issues with clients or take clients off grounds to substance abuse treatment as often as clinically appropriate, as determined by the treatment team.

(12) Adolescent clients shall be given opportunities to develop self-reliance. Emancipation shall be dealt with as a clinical and practical issue. Self-care, job training, money management, and other independent living skills, as well as referral to the ILP (Independent Living Program), JTPA (Job Training Partnership Act) and ROP (Regional Occupational Program) as needed, must be included in the program and documented in the case files.

(13) Selected Vendor(s) will provide educational assistance as needed, including help with homework, access to special tutoring, and staff attendance at Individualized Educational Plan's (IEP). Clients' individual educational needs will be respected. Clients will be assessed for learning disabilities.

(14) Selected Vendor(s) will be able to modify the treatment program to meet the needs of children who are cognitively impaired, including using the services of an Inland Regional Center-provided behavioral consultant.

(15) Selected Vendor(s) will have an organized series of planned therapeutic recreational outings and activities to increase social skills and exposure to community activities. Such activities shall include opportunities to engage in sports groups, clubs, choirs, or other activities with members of the community, as long as the treatment team has decided that the client is able to participate in a way that is safe for both the client and community. These activities will be documented in the client's file.

(16) Selected Vendor(s) will provide regular opportunities for community involvement such as charitable or volunteer activities, when the treatment team has decided that the client is able to participate in a way that is safe for both the client and community. These activities will be documented in the client's file.

(17) Residences shall contain games, books, sports equipment, art materials, music, and other recreational items such as would be found in a family home.

(18) Residences will be furnished and decorated as much like a family home as is possible, considering client and staff safety, household efficiency, and applicable state and local regulations.

(19) Selected Vendor(s) will have emergency intervention plans for both psychiatric and medical emergencies. Selected Vendor(s) will have an emergency plan and supplies in case of natural disaster. Residences will have regular drills to cope with emergencies. Both staff and clients will participate in these drills and know the emergency plans.

(20) Selected Vendor(s) will transport clients to regular appointments, school when busing is not provided by district, and to family visits if within a relatively short distance (45-minute drive one way).

d. Selected Vendor(s) may propose a program consisting of:

Medi-Cal Day Treatment Intensive and Day Rehabilitation

Day Treatment Intensive and Day Rehabilitation program services provide organized and structured multi-disciplinary treatment programs to prevent or shorten acute hospitalization or to avoid placement in a more restrictive setting. These services are provided to individuals who exhibit a serious mental and emotional disorder and occur in a therapeutic culturally sensitive and recovery-oriented environment. The billing unit for intensive Day Treatment is the full or half day.

The following Rehabilitative Mental Health Services Activities may be provided in addition to the services described above. (For further clarification, please see the definitions section of this RFP.)

(1) Assessment is the examination designed to provide formal documented evaluation or analysis of the cause or nature of the patient's mental, emotional, or behavioral disorder. Assessment services are limited to an intake examination, mental health evaluation, physical examination, and laboratory testing necessary for the evaluation and treatment of the patient's mental health needs. Relevant cultural issues and history should be included where appropriate.

(2) Crisis Intervention is a rapid emergency response service enabling the individual to cope with a crisis, while maintaining his/her status as a functioning community member, and is limited to stabilization of the presenting emergency. This service does not include Crisis Stabilization, which is provided in a 24-hour health care facility or hospital outpatient program. Service activities include but are not limited to Assessment, Evaluation, Collateral and Therapy (all billed as crisis intervention).

(3) Collateral is contacts with one or more significant support persons in the life of the individual which may include consultation and

training to assist in better utilization of services and understanding of mental illness; services include, but are not limited to, helping significant support persons to understand and accept the individual's condition and involving them in service planning and implementation of the service plan(s). Family counseling or therapy that is provided on behalf of the individual is also considered collateral.

(4) Evaluation is an appraisal of the client's developmental, social, emotional, and behavioral functioning in several areas including living situation, daily activities, social support systems, and health status. Cultural issues are to be addressed where appropriate.

(5) Medication Support Services includes the prescribing, administering, dispensing, and monitoring of psychiatric medications to alleviate the symptoms of mental illness which are provided by a staff person, within the scope of his/her profession. This service includes the evaluation of the need for medication, clinical effectiveness, and side effects of medication, obtaining informed consent or court order, medication education, and plan development related to the delivery of these services.

(6) Plan Development is the development of treatment or service plans and the monitoring of the individual's progress.

(7) Rehabilitation is a service activity that may include any or all of the following:

(a) Assistance in restoring or maintaining an individual's or group of individual's functional skills, daily living skills, social skills, grooming, personal hygiene skills, meal preparation skills, medication compliance, and support resources.

(b) Counseling of the individual and/or family.

(c) Training in leisure activities needed to achieve the individual's goals/desired results/personal milestones.

(d) Medication education.

(8) Therapeutic Behavioral Services (TBS) is an intensive, one-on-one, face-to-face, short-term outpatient treatment intervention, authorized for a specified period of time, designed to maintain the child/adolescent's residential placement at the lowest appropriate level by resolving targeted behaviors and achieving short-term treatment goals. To qualify for EPSDT Medi-Cal reimbursement for this service, a child/youth must meet criteria in sections 1, 2 and 3 below.

(a) Eligibility for TBS - must meet criteria (1) and (2).

(1) Full-scope Medi-Cal beneficiary under age 21 years.

(2) Meets Mental Health Plan (MHP) medical necessity criteria.

(b) Must meet criteria (1), (2), (3) or (4).

(1) Child is placed in a group home facility of RCL 12 or above or a locked treatment facility

(2) Child is being considered for a facility described above

(3) Child has had at least one emergency psychiatric hospitalization related to his/her current presenting disability within the preceding 24 months

(4) Child has previously received TBS while a member of the class.

(c) Demonstrate a need for TBS, - must meet criteria (1) and (2)

(1) The child is receiving other specialty mental health services.

(2) After clinical assessment it is determined that without the additional short-term support of TBS, the child will:

(i) Need to be placed at a higher level of care; or

(ii) Not be able to transition to lower level of care.

(9) Therapy is a service activity that may be delivered to an individual or group of individuals and may include family therapy (when the individual is present). Therapeutic interventions are consistent with the individual's goals, desired results, any personal milestones and focus primarily on symptom reduction as a means to improved functional impairments.

e. Selected Vendor(s) program staffing should be multi-disciplinary and reflect the cultural, linguistic, ethnic, age, gender, sexual orientation and other social characteristics of the community in which the program serves. Families, caregivers, human service agency personnel and

other significant support persons should be encouraged to participate in the planning and implementation process in responding to the individual's needs and desires, and in facilitating the individual's choices and responsibilities. This program may be designed to use both licensed and non-licensed personnel who are experienced in providing mental health services.

f. Staffing

(1) All staff shall be employed by the selected Vendor(s). The staff described will work the designated number of hours per week in full time equivalents (FTE's), perform the job functions specified, and shall meet the California Code of Regulations requirements. All treatment staff providing services with DBH funding shall be licensed or waivered by the State and reflect the ethnic population of the community served.

(2) All copies of licenses and registration/waivers will be provided to the DBH contract monitor and the DBH Contracts Unit, including current status and future updates on an as needed basis.

(3) Vacancies or changes in staffing plan shall be submitted to the appropriate DBH Program Manager within 48 hours of selected Vendor(s)'s knowledge of such occurrence. Such notice shall include a plan of action to address the vacancy or a justification for the staffing plan change.

E. Program Considerations

1. Evaluation Requirements – Proposers must demonstrate the technical capacity to identify performance objectives and to collect and report data on program performance and outcomes. Proposers awarded Contracts in response to this RFP will be required to participate in a countywide evaluation system currently being developed to evaluate prevention, treatment, and recovery programs.

2. Selected Vendor(s) will ensure that personnel possess appropriate licenses and certificates and be qualified in accordance with applicable statutes and regulations. Selected Vendor(s) will obtain, maintain and comply with all necessary government authorizations, permits and licenses required to conduct its operations. In addition, selected Vendor(s) will comply with all applicable Federal, State and local laws, rules, regulations and orders in its operations, including compliance with all applicable safety and health requirements as to employees.

3. Cultural Competency

DMH mandates counties to develop and implement a Cultural Competency Plan for residents of San Bernardino County. Policies, procedures and all

services must be culturally and linguistically appropriate. Selected Vendor(s) will be included in the implementation process and shall adhere to cultural competency standards and requirements.

Cultural and Linguistic Competency is defined as a set of congruent practice behaviors, attitudes and policies that come together in a system, agency or among consumer providers and professionals that enable that system, agency or those professional and consumer providers to work effectively in cross-cultural situations.

a. Selected Vendor(s) shall be required to assess the demographic make-up and population trends of its service area to identify the cultural and linguistic needs of the eligible beneficiary population. Such studies are critical to designing and planning for providing appropriate and effective behavioral health and substance abuse services.

b. DBH recognizes that cultural competence is a goal toward which professionals, agencies, and systems should strive. Becoming culturally competent is a developmental process and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs. Providing medically necessary specialty behavioral health and substance abuse services in a culturally competent manner is fundamental in any effort to ensure success of high quality and cost effective behavioral health and substance abuse services. Offering those services in a manner that fails to achieve its intended result due to cultural and linguistic barriers is not cost effective.

c. To assist selected Vendor(s) in efforts towards cultural and linguistic competency, the DBH shall provide the following:

(1) Technical assistance regarding cultural competency requirements.

(2) Demographic information concerning service areas for planning purposes.

(3) Cultural competency training for personnel. Personnel are encouraged to attend at least one cultural competency training per year.

(4) Interpreter training.

(5) Technical assistance in translating behavioral health and substance abuse services information into DBH's threshold language(s).

F. Contract Reimbursement

1. Contracts are typically funded annually on a July 1 - June 30, fiscal year basis. Funding is subject to availability. Any unspent fiscal year allocation does not roll over and is not available in future years

2. Pursuant to a Contract between the County and selected Vendor(s), reimbursement to a Vendor for providing the Children's Residential Mental Health Services to children placed in an RCL –14 Program is limited to the amount allocated to the program Contract on an annual basis, not to exceed the maximum annual obligation of the County under any such Contract.

3. Reimbursement for mental health services will be claimed through the EPSDT Medi-Cal system as Mental Health Services for outpatient programs. Selected Vendor(s) shall be a certified Medi-Cal provider or eligible to become certified. Reimbursement will be made consistent with other specialty mental health services.

   The selected Vendor(s) will be reimbursed based on the following:

   (a) In accordance with State of California audit/reimbursement policies, the County shall agree to compensate selected Vendor(s) for actual costs incurred up to SMA, or actual claimed costs incurred in performing the services described in any Contract up to the maximum annual financial obligation of the Contract.

   (b) Selected Vendor(s) currently under contract with DBH to provide Medi-Cal services shall use their existing Medi-Cal rates;

   (c) Rates for selected Vendor(s) not currently under Contract with DBH will be negotiated between DBH and the Vendor, based upon the Budget **(Attachments E and F)** submitted with the proposal. Negotiated rates shall not exceed the SMA.

4. The Residential Program Component, or placement costs, will be reimbursed via the current standard residential funding streams for RCL – 14 residential foster care. The Residential Program costs will remain separate from DBH in terms of any form of fiscal reimbursement.

5. Selected Vendor(s) shall bill the County monthly in arrears on claim forms provided by County. During the term of any Contract, the County shall make interim payments in arrears on a monthly basis. All payments are subject to a cost report.

6. Not later than 75 days after the fiscal year ends or expiration or termination of a Contract, whichever comes first, unless otherwise notified by County, the selected Vendor(s) shall provide the DBH with a complete and correct annual standard State of California Cost Report and a complete and correct State of California Cost Report for Medi-Cal services, when appropriate.

V. CONTRACT REQUIREMENTS

A. General

The Vendor(s) selected may be required to agree to the terms contained below. If the Proposer has any objections, these objections must be addressed in the RFP response to the County or the objections will be deemed to have been waived.

1. Representation of the County

   In the performance of the Contract, Contractor, its agents and employees, shall act in an independent capacity and not as officers, employees, or agents of County of San Bernardino.

2. Contract Primary Contact

   The Vendor(s) will designate an individual to serve as the primary point of contact for the Contract. Vendor(s) shall notify DBH when the primary contact will be unavailable/out of the office for one (1) or more business days. Vendor(s) or designee must respond to County inquiries within two (2) County business days.

3. Change of Address

   Vendor shall notify the County in writing of any change in mailing address within ten (10) days of the address change.

4. Contract Assignability

   Without the prior written consent of the County, the Contract is not assignable by Vendor either in whole or in part.

5. Subcontracting

   Selected Vendor(s) agrees not to enter into any subcontracts for work contemplated under the Contract without first obtaining written approval from the County of San Bernardino Department of Behavioral Health. Any subcontractor shall be subject to the same provisions as Vendor. Vendor shall be fully responsible for the performance of any subcontractor.

6. Contract Amendments

   Vendor agrees any alterations, variations, modifications, or waivers of provisions of the Contract shall be valid only when they have been reduced to writing, duly signed and attached to the original of the Contract and approved by the required persons and organizations.

7. Copyright

   County shall have a royalty-free, non-exclusive and irrevocable license to publish, disclose, copy, translate, and otherwise use, copyright or patent, now and hereafter, all reports, studies, information, data, statistics, forms, designs, plans, procedures, systems, and any other materials or properties developed under a Contract including those covered by copyright, and reserves the right to

authorize others to use or reproduce such material. All such materials developed under the terms of a Contract shall acknowledge the County of San Bernardino as the funding agency and Vendor as the creator of the publication. No such materials or properties produced in whole or in part under a Contract shall be subject to private use, copyright or patent right by Vendor in the United States or in any other country without the express written consent of County. Copies of all educational and training materials, curricula, audio/visual aids, printed material, and periodicals, assembled pursuant to a Contract awarded must be filed with County prior to publication. Vendor shall receive written permission from County prior to publication of said training materials.

8. Attorney Fees

Vendor agrees to bear its own attorneys' fees and costs regardless of who prevails in the event of a contractual dispute and not charge such fees as an expense under a Contract.

9. Conflict of Interest

Vendor shall make all reasonable efforts to ensure that no conflict of interest exists between its officers, employees, or subcontractors and the County. Vendor shall make a reasonable effort to prevent employees, consultants, or members of governing bodies from using their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others such as those with whom they have family, business, or other ties.

Officers, employees, and agents of cities, counties, districts, and other local agencies are subject to applicable conflict of interest codes and State law, including Section 23-602 (Code of Conduct) of Chapter 23-600 of the CDSS Manual of Policies and Procedures. In the event that County determines that a conflict of interest situation exists, any increase in costs associated with the conflict of interest situation may be disallowed by County and such conflict may constitute grounds for termination of a Contract.

This provision shall not be construed to prohibit employment of persons with whom Contractor's officers, employees, or agents have family, business, or other ties so long as the employment of such persons does not result in increased costs over those associated with the employment of any other equally qualified applicant.

10. Grievance Procedure

Vendor will ensure that staff are knowledgeable concerning the San Bernardino County Mental Health Plan (MHP) Grievance Procedure (see Attachment C) and ensure that any complaints by recipients are referred to the County in accordance with the procedure.

11. Confidentiality

a. Vendor shall comply with all state and federal statutes and regulations regarding confidentiality, including but not limited to, the confidentiality of

information requirements in 42 United States Code Section 290 dd-2; Title 42, Code of Federal Regulations part 2; Welfare and Institutions Code Sections 5328 et seq and 14100.2; Sections 11878, 11812, and 11977 of the Health and Safety Code; and Title 22, California Code of Regulations Section 51009.

b. No list of persons receiving services under a Contract shall be published, disclosed, or used for any purpose except for the direct administration of the program or other uses authorized by law that are not in conflict with requirements for confidentiality listed above.

c. Vendor shall require its officers, agents, employees, volunteers and any subcontractor to comply with the applicable provisions of 42CFR, Part 2, Section 10850 and 827 of the W&I Code and Division 19-000 of the CDSS Manual of Policies and Procedures to assure that:

(1) All applications and records concerning any individual made or kept by any public officer or agency or Vendor in connection with the administration of any provision of the 42CFR, Part 2 and W & I Code relating to any forms of public social services for which funds are received by the Vendor under a Contract will be confidential and will not be open to examination for any purpose not directly connected with the administration, performance, compliance, monitoring or auditing of such services.

(2) No person will publish or disclose, or use or permit, or cause to be published or disclosed or used, any confidential information pertaining to any applicant or recipient of services under a Contract.

d. Vendor(s) agrees to inform all subcontractors, consultants, employees, agents, and partners of the above provisions and that any person knowingly and/or intentionally violating the provisions of this article is guilty of a misdemeanor.

12. Records

Vendor(s) shall maintain all records and management books pertaining to local service delivery and demonstrate accountability for contract performance and maintain all fiscal, statistical, and management books and records pertaining to the program.

Records, should include, but are not limited to, monthly summary sheets, sign-in sheets, and other primary source documents. Fiscal records shall be kept in accordance with Generally Accepted Accounting Principles and must account for all funds, tangible assets, revenue and expenditures. Fiscal records must also comply with the appropriate Office of Management and Budget (OMB) Circulars which state the administrative requirements, cost principles and other standards for accountancy and shall be retained for at least seven years from the date of final payment or final settlement, or until audit findings are resolved, whichever is longer.

All records shall be complete and current and comply with all Contract requirements. Failure to maintain acceptable records per the preceding requirements shall be considered grounds for withholding of payments for billings submitted and for termination of a Contract.

The Vendor shall maintain client and community service records in compliance with all regulations set forth by the State Department of Mental Health (DMH) and provide access to clinical records by DBH staff.

Vendor(s) shall agree to maintain and retain all appropriate service and financial records for a period of at least seven (7) years, or until audit findings are resolved, whichever is later.

13. Revenues

The Vendor shall collect revenues for the provision of the services described in the RFP. Such revenues may include, but are not limited to, fees for services, private contributions, grants or other funds. All revenues and food stamps collected from the treatment facility residents shall be used to offset the cost of services and should, therefore, be considered in computing the proposed net reimbursement rate(s).

14. Invoices

a. Vendor shall submit its claims to DBH monthly in arrears and at those times required by County. County shall supply the Contractor with the necessary claim form.

b. The amount reimbursed to Vendor for services rendered shall not exceed that allowed by applicable Federal, State and County regulations.

c. In the event of a reduction of County's allocation from Realignment and/or other categorical funds, Vendor agrees to accept a reduction in funding under a Contract not to exceed that percentage reduction made to the County allocation.

15. Licenses and Permits

Vendor will ensure that it has all necessary licenses and permits required by the laws of the United States, State of California, County of San Bernardino and all other appropriate governmental agencies, and agrees to maintain these licenses and permits in effect for the duration of a Contract. Vendor will notify DBH immediately of loss or suspension of any such licenses and permits.

16. Health and Safety

Vendor shall comply with all applicable state and local health and safety clearances, including fire clearances, for each site where program services are provided under the terms of a Contract.

17. Department of Justice Clearance

Vendor shall obtain from the Department of Justice (DOJ) records of all convictions involving any sex crimes, drug crimes, or crimes of violence of a person who is offered employment or volunteers for all positions in which he or she would have contact with a minor, the aged, the blind, the disabled or a domestic violence client, as provided for in Penal Code Section 11105.3. This includes licensed personnel who are not able to provide documentation of prior Department of Justice clearance. A copy of a professional license issued by the State of California is sufficient proof.

18. Americans with Disabilities Act

Vendor shall comply with all applicable provisions of the Americans with Disabilities Act (ADA).

19. Public Accessibility

Vendor shall ensure that services provided are accessible by public transportation.

19. Notification

In the event of a problem or potential problem that will impact the quality or quantity of work or the level of performance under a Contract, notification will be made within one business day, in writing and by telephone to the County.

20. Audits

The County will conduct four types of audits: program, Medi-Cal, Fiscal and contract monitoring during the fiscal year.

B. Indemnification and Insurance Requirements

1. Indemnification

The Vendor agrees to indemnify, defend and hold harmless the County and its authorized officers, employees, agents and volunteers from any and all claims, actions, losses, damages, and/or liability arising out of the Contract from any cause whatsoever, including the acts, errors or omissions of any person and for any costs or expenses incurred by the County on account of any claim therefore, except where such indemnification is prohibited by law.

2. Insurance

Without in any way affecting the indemnity herein provided and in addition thereto, the Vendor shall secure and maintain throughout the Contract the following types of insurance with limits as shown:

a. Workers' Compensation - A program of Workers' Compensation insurance or a State-approved Self-Insurance Program in an amount and form to meet all applicable requirements of the Labor Code of the State of California, including Employer's Liability with two hundred fifty thousand dollars ($250,000) limits, covering all persons providing

services on behalf of the Vendor and all risks to such persons under the Contract.

If Vendor has no employees, it may certify or warrant to County that it does not currently have any employees or individuals who are defined as "employees" under the Labor Code and the requirement for Workers' Compensation coverage will be waived by the County's Risk Manager.

With respect to Vendors that are non-profit corporations organized under California or Federal law, volunteers for such entities are required to be covered by Workers' Compensation insurance. If the County's Risk Manager determines that there is no reasonably priced coverage for volunteers, evidence of participation in a volunteer insurance program may be substituted.

b. Comprehensive General and Automobile Liability Insurance - This coverage to include contractual coverage and automobile liability coverage for owned, hired and non-owned vehicles. The policy shall have combined single limits for bodily injury and property damage of not less than one million dollars ($1,000,000).). **Exception: If the Vendor is going to transport clients at any given time, then the policy shall have combined single limits for bodily injury and property damage of not less than two million ($2,000,000).**

c. Errors and Omission Liability Insurance – Combined single limits of one million ($1,000,000) and three million ($3,000,000) in the aggregate or

Professional Liability – Professional liability insurance with limits of at least one million ($1,000,000) per claim or occurrence.

3. Additional Named Insured

All policies, except for the Workers' Compensation, Errors and Omissions and Professional Liability policies, shall contain additional endorsements naming the County and its officers, employees, agents and volunteers as additional named insured with respect to liabilities arising out of the performance of services hereunder.

4. Waiver of Subrogation Rights

Except for the Errors and Omissions Liability and Professional Liability, Vendor shall require the carriers of the above-required coverages to waive all rights of subrogation against the County, its officers, employees, agents, volunteers, Contractors and subcontractors.

5. Policies Primary and Non-Contributory

All policies required above are to be primary and non-contributory with any insurance or self-insurance programs carried or administered by the County.

6. Proof of Coverage

Vendor shall immediately furnish certificates of insurance to the County Department administering the Contract evidencing the insurance coverage, including endorsements above, required prior to the commencement of

performance of services hereunder, which certificates shall provide that such insurance shall not be terminated or expire without thirty (30) days written notice to the Department, and Vendor shall maintain such insurance from the time Vendor commences performance of services hereunder until the completion of such services. Within sixty (60) days of the commencement of the Contract, the Vendor shall furnish certified copies of the policies and all endorsements. If the copies and endorsements are not received within the specified time, the Department may with hold contractual reimbursement until the copies and endorsements are provided.

7. Insurance Review

The above insurance requirements are subject to periodic review by the County. The County's Risk Manager is authorized, but not required, to reduce or waive any of the above insurance requirements whenever the Risk Manager determines that any of the above insurance is not available, is unreasonably priced, or is not needed to protect the interests of the County. In addition, if the Risk Manager determines that heretofore unreasonably priced or unavailable types of insurance coverage or coverage limits become reasonably priced or available, the Risk Manager is authorized, but not required, to change the above insurance requirements, to require additional types of insurance coverage or higher coverage limits, provided that any such change is reasonable in light of past claims against the County, inflation, or any other item reasonably related to the County's risk.

Any such reduction or waiver for the entire term of the Contract and any change requiring additional types of insurance coverage or higher coverage limits must be made by amendment to the Contract. Vendor agrees to execute any such amendment within thirty (30) days of receipt.

C. Right to Monitor and Audit

1. Right to Monitor

County or any subdivision or appointee thereof, and the State of California or any subdivision or appointee thereof, including the Auditor General, shall have absolute right to review, audit, inspect and make copies of all records related to any contract awarded under this procurement (including service records), books, papers, documents, corporate minutes, and other pertinent items as requested to evaluate the cost, quality, appropriateness and timeliness of services performed; and shall have absolute right to monitor the performance of Vendor in the delivery of services provided under the Contract. Vendor shall cooperate with County in the implementation, monitoring and evaluation of this agreement and comply with any and all reporting requirements established by County.

2. Availability of Business Records

All records pertaining to service delivery and all fiscal, statistical and management books and records shall be available for examination and audit by County, Federal and State representatives for a period of at least seven years after final payment under the Contract or until all pending County, State and Federal audit findings are completed, whichever is later. Program data shall be

retained locally (in the County) and made available upon request or turned over to County. If said records are not made available at the scheduled monitoring visit, Vendor may, at County's option, be required to reimburse County for expenses incurred due to required rescheduling of monitoring visit(s). Such reimbursement will not exceed fifty dollars ($50) per hour (including travel time) and be deducted from the following month's claim for reimbursement.

3. Availability of Medical Records

a. Vendor shall agree to maintain and retain medical and or service records, including sign in sheets, accordance to the following provisions:

The minimum legal requirement for the retention of medical records is:

(1) For adults and emancipated minors, seven years following discharge (last date of service).

(2) For unemancipated minors, at least one year after they have attained the age of 18, but in no event less than seven years following discharge (last date of service).

(3) Vendor shall agree to censure that all patient/client records comply with any additional applicable State and Federal requirements.

4. Assistance by Vendor

Vendor shall provide all reasonable facilities and assistance for the safety and convenience of County's representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work of the Vendor.

5. Inspection and Independent Audit Provisions

With regard to the services described herein, the County of San Bernardino, or the appropriate audit agency of the State of California, will have the right to audit and inspect all books and records to evaluate the cost, quality, appropriateness and timeliness of services performed.

a. The audit shall be performed in accordance with OMB Circular A-133 (latest revision), Audits of States, Local Governments, and Non-Profit Organizations.

b. The audit shall be conducted in accordance with generally accepted auditing standards and Government Auditing Standards, latest edition, issued by the Comptroller General of the United States.

Vendor will hire a licensed Certified Public Accountant (CPA), approved by County, who shall prepare and file with County, within 60 days after the termination of the Contract, a certified fiscal audit of related expenditures during the term of the Contract and a program compliance audit.

Pursuant to OMB Circular A-133, Contractors expending the threshold amount or more in Federal funds in a year through a Contract with County must have a single or program-specific audit performed. A copy of the audit performed in accordance with OMB Circular A-133 shall be submitted to the County within

thirty (30) days of completion, but no later than nine (9) months following the end of the Contractor's fiscal year.

VI. EQUAL EMPLOYMENT OPPORTUNITY/CIVIL RIGHTS

Vendor agrees to comply with the provisions of the Equal Employment Opportunity Program of the County of San Bernardino and rules and regulations adopted pursuant thereto: Executive Order 11246, as amended by Executive Order 11375, 11625, 12138, 12432, 12250, Title VII of the Civil Rights Act of 1964, the California Fair Employment and Housing Act, and other applicable Federal, State, and County laws, regulations and policies relating to equal employment or social services to welfare recipients, including laws and regulations hereafter enacted.

The Vendor shall not unlawfully discriminate against any employee, applicant for employment, or service recipient on the basis of race, color, national origin or ancestry, religion, sex, sexual orientation, marital status, age, political affiliation or disability.

VII. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), regulations have been promulgated governing the privacy and security of individually identifiable health information (IIHI) otherwise defined as Protected Health Information (PHI) or electronic Protected Health Information (ePHI). The HIPAA Privacy and Security Regulations specify requirements with respect to contracts between an entity covered under the HIPAA Privacy and Security Regulations and its Business Associates. A Business Associate is defined as a party that performs certain services on behalf of, or provides certain services for, a Covered Entity and, in conjunction therewith, gains access to IIHI, or PHI or ePHI. Therefore, in accordance with the HIPAA Privacy and Security Regulations, Contractor shall comply with the terms and conditions as set forth in the attached Business Associate Agreement, hereby incorporated by this reference as Attachment D.

VIII. FORMER COUNTY OFFICIALS

The Proposer shall provide information on former County of San Bernardino administrative officials (as defined below) who are employed by or represent its business. The information provided must include a list of former County administrative officials who terminated County employment within the last five years and who are now officers, principals, partners, associates or members of the business. This should also include the employment and/or representative capacity and the dates these individuals began employment with or representation of the business. For purposes of this section, "County administrative official" is defined as a member of the Board of Supervisors or such officer's staff, County Administrative Officer or member of such officer's staff, County department or group head, assistant department or group head, or any employee in the Exempt Group, Management Unit or Safety Management Unit.

Failure to provide this information may result in the response to the RFP being deemed non-responsive.

IX. IMPROPER CONSIDERATION

The Proposer shall not offer (either directly or through an intermediary) any improper consideration such as, but not limited to, cash, discounts, service, the provision of travel or

entertainment, or any items of value to any officer, employee or agent of the County in an attempt to secure favorable treatment regarding this RFP.

The County, by written notice, may immediately reject any proposal or terminate any Contract if it determines that any improper consideration as described in the preceding paragraph was offered to any officer, employee or agent of the County with respect to the proposal and award process or any solicitation for consideration was not reported. This prohibition shall apply to any amendment, extension or evaluation process once a Contract has been awarded.

Proposer shall immediately report any attempt by a County officer, employee or agent to solicit (either directly or through an intermediary) improper consideration from Proposer. The report shall be made to the supervisor or manager charged with supervision of the employee or to the County Administrative Office. In the event of a termination under this provision, the County is entitled to pursue any available legal remedies.

X. DISCLOSURE OF CRIMINAL AND CIVIL PROCEEDINGS

The County reserves the right to request the information described herein from the Proposer selected for Contract award. Failure to provide the information may result in a disqualification from the selection process and no award of Contract to the Proposer. The County also reserves the right to obtain the requested information by way of a background check performed by an investigative firm. The selected Proposer also may be requested to provide information to clarify initial responses. Negative information provided or discovered may result in disqualification from the selection process and no award of Contract.

The selected Proposer may be asked to disclose whether the firm or any of its partners, principals, members, associates or key employees (as that term is defined herein), within the last ten (10) years, has been indicted on or had charges brought against it or them (if still pending) or convicted of any crime or offense arising directly or indirectly from the conduct of the firms business, or whether the firm, or any of its partners, principals, members, associates or key employees, has within the last ten (10) years, been indicted on or had charges brought against it or them (if still pending) or convicted of any crime or offense involving financial misconduct or fraud. If the response is affirmative, the Proposer will be asked to describe any such indictments or charges (and the status thereof), convictions and the surrounding circumstances in detail.

In addition, the selected Proposer may be asked to disclose whether the firm, or any of its partners, principals, members, associates or key employees, within the last ten (10) years, has been the subject of legal proceedings as defined herein arising directly from the provision of services by the firm or those individuals. “Legal proceedings” means any civil actions filed in a court of competent jurisdiction, or any matters filed by an administrative or regulatory body with jurisdiction over the firm or the individuals. If the response is affirmative, the Proposer will be asked to describe any such legal proceedings (and the status and disposition thereof) and the surrounding circumstances in detail.

For the purposes of this provision “key employees” includes any individuals providing direct service to the County. “Key employees” do not include clerical personnel providing service at the firm’s offices of locations.

XI. CALIFORNIA PUBLIC RECORDS ACT

All information submitted in the proposal or in response to request for additional information is subject to disclosure under the provisions of the California Public Records Act, Government Code Section 6250 and following. Proposals may contain financial or other data which constitutes a trade secret. To protect such data from disclosure, Proposer should specifically identify the pages that contain confidential information by properly marking the applicable pages and inserting the following notice on the front of its response:

NOTICE

> The data on pages_____ of this Proposal response, identified by an asterisk (*) or marked along the margin with a vertical line, contains information which are trade secrets. We request that such data be used only for the evaluation of our response, but understand that disclosure will be limited to the extent that the County of San Bernardino determines is proper under federal, state, and local law.

The proprietary or confidential data shall be readily separable from the Proposal in order to facilitate eventual public inspection of the non-confidential portion of the Proposal.

The County assumes no responsibility for disclosure or use of unmarked data for any purpose. In the event disclosure of properly marked data is requested, the Proposer will be advised of the request and may expeditiously submit to the County a detailed statement indicating the reasons it has for believing that the information is exempt from disclosure under federal, state and local law. This statement will be used by the County in making its determination as to whether or not disclosure is proper under federal, state and local law.

The County will exercise care in applying this confidentiality standard but will not be held liable for any damage or injury which may result from any disclosure that may occur.

XII. PROPOSAL SUBMISSION

A. General

1. All interested and qualified Proposers are invited to submit a proposal for consideration. Submission of a proposal indicates that the Proposer has read and understands this entire RFP, to include all appendices, attachments, exhibits, schedules, and addendum (as applicable) and that all aspects regarding this RFP have been satisfied.
2. Proposals must be submitted in the format described below. Proposals are to be prepared in such a way as to provide a straightforward, concise description of capabilities to satisfy the requirements of this RFP. Expensive bindings, colored displays, promotional materials, etc., are not necessary nor desired. Emphasis should be concentrated on conformance to the RFP instructions, responsiveness to the RFP requirements, and on completeness and clarity of content.
3. Proposals must be complete in all respects as required in this section. A proposal may not be considered if it is conditional or incomplete.
4. **Proposals must be received no later than the date and time at the designated location as specified in Section I, Paragraph E - Proposal Submission Deadline.**

5. All proposals and materials submitted become the property of the County.

B. Proposal Presentation

1. An original, which may be bound, and six (6) unbound copies of the written proposal are required. The original copy must be clearly marked "Master Copy". If one copy of the proposal is not clearly marked "Master Copy", the proposal may be rejected. However, the County may at its sole option select, immediately after proposal opening, one copy to be used as the Master Copy. If discrepancies are found between two or more copies of the proposal, the proposal may be rejected. However, if not rejected, the Master Copy will provide the basis for resolving such discrepancies.

2 The package containing the original and copies must be sealed and marked with the Proposer's name and "**CONFIDENTIAL - CHILDREN'S RESIDENTIAL MENTAL HEALTH SERVICES (RCL 14) – RFP – 05 – 79**.''

3. All proposals must be submitted on 8 1/2" by 11" recycled paper with double sided printing, unless specifically shown to be impracticable, with no less than one half inch 1/2" top, bottom, left and right margins. Proposals must be typed or prepared with word processing equipment and double-spaced. Typeface must be no more than twelve (12) characters per inch. Each page, including attachments and exhibits, must be clearly and consecutively numbered at the bottom center of the page.

4. Proposers wishing to request a waiver of the County policy requiring that proposals be submitted on two-sided recycled paper must include such request and reasons on the cover letter of the proposal.

C. Proposal Format

Response to this RFP must be in the form of a proposal package and **the content must be submitted in the following sequence and format:**

1. Cover Page - Submit a letter, on letterhead stationary which reflects the Proposer's legal business name, mailing address, facility address (if different from mailing address), telephone number, fax number and e-mail address. The letter must be signed by a duly authorized officer, employee, or agent of the organization/firm submitting the proposal and must include the following information:

   a. A statement that the proposal is submitted in response to the RFP "**Children's Residential Mental Health Services (RCL – 14) for the Youth Crisis Residential Placement Program, RFP DBH – 05 – 79**".

   b. A statement indicating which individuals, by name, title, address, and phone number, are authorized to negotiate with the County on behalf of the organization/firm.

   c. A statement certifying that the undersigned, under penalty of perjury, is an agent authorized to submit proposals on behalf of the organization/firm.

2. Table of Contents - A complete table of contents for the entire proposal with respective page numbers opposite each topic is to be included.

3. Statement of Certification - Include the following in this section of the proposal:

   a. A concise statement of the service proposed *and* the overall cost or cost per transaction proposed **for each fiscal year of any resulting Contract**.

   b. A statement that the Proposer will provide the services as described in the proposal for the time period August 1, 2006 through July 31, 2007.

   c. A statement that the offer made in the proposal is firm and binding for 120 days from the date the proposal is opened and recorded.

   d. A statement that all aspects of the proposal, including cost and units of service, have been determined independently, without consultation with any other Vendor or competitor for the purpose of restricting competition.

   e. A statement that all declarations in the proposal and attachments are true and that this shall constitute a warranty, the falsity of which shall entitle the County to pursue any remedy by law.

   f. A statement that the Proposer agrees that all aspects of the RFP and the proposal submitted shall be binding if the proposal is selected and a Contract awarded.

   g. A statement that the Proposer agrees to provide the County with any other information that the County determines is necessary for an accurate determination of the Proposer's ability to perform services as proposed.

   h. A statement that the Proposer, if selected, will comply with all applicable rules, laws, and regulations.

   i. A list of Former County Officials (as defined in Section VIII) affiliated with the organization. If none, so state.

4. Proposal Description – This is a detailed description of the proposal being made.

   a. Proposal shall address, but not be limited to, all items in Section IV Program Description, Paragraph D Program Requirements.

   b. Proposal shall include the following:

      (1) Brief synopsis of the Proposer's understanding of the County's needs and how the Proposer plans to meet these needs. This should provide a broad understanding of the Proposer's entire proposal.

      (2) Narrative description of the proposed plan to achieve the program objective and requirements.

      (3) Detailed plan of activities

      This section must include the following information:

         (a) Proposer's business location, accessibility by public transportation and hours of operation.

         (b) Detailed description of the treatment program, with special emphasis on services to the priority population of dually

diagnosed adolescent with mental health disorders and substance abuse problems.

(c) Staffing for the program, including basic level of responsibilities, duties, supervisory structure, level of authority and experience of staff members.

(d) Description of the Program's crisis response plan to ensure 24 hours, 7 days per week coverage.

(3) Narrative on how the Proposer will meet any Program Considerations as required.

(4) Explanation of any assumptions and/or constraints.

5. Statement of Experience - Include the following in this section of the proposal:

a. Business name of the Proposer and legal entity such as corporation, partnership, etc.

b. Provide Articles of Incorporation, bylaws, partnership agreements, including all amendments, unless currently on file with the County of San Bernardino DBH.

c. Provide a listing of names and addresses of board of directors, corporate officers or partners.

d. Number of years the Proposer has been in business under the present business name, as well as related prior business names.

e. A statement that the Proposer has a demonstrated capacity to perform the required services.

f. Provide copies of any required licenses or statements or intent to obtain same to include local business licenses and permits, unless currently on file with the County of San Bernardino.

g. A statement that the Proposer is an organization that is adequately staffed and trained to perform the required services or demonstrate the capability for recruiting such staff.

h. Experience of principal individuals of the Proposer's present organization in the areas of financial and management responsibility, including names of principal individuals, current position or office and their years of service experience, including capacity, magnitude and type of work.

i. With respect to Contracts completed during the last five years, which involve similar type projects, show for each such Contract:

(1) Date of completion and duration of each Contract.

(2) Type of service.

(3) Total dollar amount contracted for and amount received.

(4) Location of area served.

(5) Name and address of agency with which contracted and agency person administering the Contract.

(6) If none, so state.

j. If any Contract was terminated prior to the original termination date during the last five years, show for each Contract:

(1) Date of termination and duration of each Contract.

(2) Type of service.

(3) Total dollar amount contracted for and amount received.

(4) Location of area served.

(5) Name and address of agency with which contracted and agency person administering the Contract.

(6) Reason for termination.

(7) If none, so state.

k. With respect to Contracts currently in effect, show the following for each such contract:

(1) Date due for completion and duration of Contract.

(2) Type of service.

(3) Total Contract amount.

(4) Location of area served.

(5) Name and address of agency with which the organization is currently contracting and agency person administering the Contract.

(6) If none, so state.

l. Controlling interest in any other firms providing equivalent or similar services. If none, so state.

m. Financial interest in other lines of business. If none, so state.

n. Pending litigation, involving Proposer or any officers, employees, and/or consultants thereof, in connection with Contracts. If none, so state.

o. Convictions or adverse court rulings involving fraud and/or related acts of all officers, consultants, and employees. If none, so state.

p. A statement that the Proposer does not have any commitments or potential commitments which may impact on the Proposer's assets, lines of credit, guarantor letters, or ability to perform the Contract.

q. A statement by the Proposer certifying that neither it nor its principles is presently disbarred, suspended, proposed for disbarment, declared ineligible or voluntarily excluded from participation in transactions with federal departments or agencies

6. Subcontractor Information - If a Proposer plans to subcontract any portion of the service delivery described in this RFP, include a written justification for subcontracting. Attach a statement from each subcontractor, signed by a duly

authorized officer, employee, or agent of the organization/firm that includes the name and address of the organization/firm, type of work to be performed, percentage of the total work of the proposal. Statement must also include that the subcontractor will perform all work as indicated and will comply with all items as described herein. This information will be used to determine the potential responsibility of the Proposer.

Any subcontract entered into by the Proposer upon award of a Contract shall be subject to the applicable requirements of CDSS MPP Division 23, Section 604, and the Proposer shall be responsible for performance of the subcontractor.

7. Audited financial statements - Such statements shall be the most recent and complete audited financial statement available and shall be for a fiscal period not more than eighteen (18) months old at time of submission. The financial statements shall be prepared by an independent, certified public accountant. If the audit is of a parent firm, the parent firm shall be party to the Contract. Individuals who are personally performing the contracted services and governmental agencies are exempt from this requirement.

   In accordance with CDSS MPP Section 23-610(L), if applicable, submit the most recent and complete three annual audited financial statements; the most recent must be completed within the past 18 months. If the business has been in existence for less than three years, provide the most recent statements. These statements shall be by an independent, certified public accountant.

   In accordance with CDSS MPP Section 23-610(m), if applicable, submit an unaudited financial statement to cover the period from the last audited statement to present, ending no more than 120 days prior to the date of submission of this proposal.

   Although it is in the best interest of the Proposer to submit audited financial statements, a compilation of financial statements will be accepted. Compilations must meet the same requirements as audited financial statements described in this RFP.

   Right to Audit - Submit a signed statement by a duly authorized officer, employee or agent of the organization/firm as to the right of the County, State and Federal governments to audit the prospective Proposer's financial and other records.

8. Insurance - Submit evidence of ability to obtain insurance in the amounts and coverages stated in Section V, Paragraph B - Indemnification and Insurance Requirements.

9. Budgets - Proposers must complete the attached Annual Program Budget Detail Sheets (Attachments E & F) for the fiscal year.

XIII. PROPOSAL EVALUATION AND SELECTION

A. Evaluation Process

All proposals will be subject to a standard review process developed by County. A primary consideration shall be the effectiveness of the agency or organization in the delivery of comparable or related services based on demonstrated performance. **All**

requirements listed in Section XII Proposal Requirements, are obligatory and failure to comply may eliminate a proposal from consideration.

B. Evaluation Criteria

1. Initial Review - All proposals will be initially evaluated to determine if they meet the following minimum requirements:

   a. The proposal must be complete, in the required format, and be in compliance with all the requirements of this RFP.

   b. Prospective Contractors must meet the requirements stated in the Minimum Proposer Requirements as outlined in Section I, Paragraph B.

   Failure to meet all of these requirements may result in a rejected proposal. No proposal shall be rejected, however, if it contains a minor irregularity, defect or variation if the irregularity, defect or variation is considered by the County to be immaterial or inconsequential. In such cases the Proposer will be notified of the deficiency in the proposal and given an opportunity to correct the irregularity, defect or variation or the County may elect to waive the deficiency and accept the proposal.

2. Evaluation - Proposals meeting the above requirements will be evaluated on an ordinal ranking system. Evaluation will include a thorough review of all documentation. Special consideration will be given to the following criteria:

   a. Cost of service.

   b. Location of Residential Care facility(ies).

   c. Proposer experience with residential care.

   d. Proposer experience with child and family outpatient services

Selection will be based on determination of which proposal(s) will best meet the needs of the County and the requirements of this RFP.

C. Contract Award

Contract(s) will be awarded based on a competitive selection of proposals received.

The contents of the proposal of the successful Proposer will become contractual obligations and failure to accept these obligations in a Contract may result in cancellation of the award.

D. Protests

Proposers may protest the recommended award, provided the protest is in writing, contains the RFP number, is delivered to the address listed in Section I, Paragraph D of this RFP, and submitted within ten (10) calendar days of the date on the notification of intent to award.

Grounds for a protest are that the County failed to follow the selection procedures and adhere to requirements specified in the RFP or any addenda or amendments; there has been a violation of conflict of interest as provided by California Government Code Section 87100 et seq.; or violation of State or Federal law. In event of a

protest, all protests will be handled by a panel designated by the County Administrative Office (CAO), or designee.

The County will consider only those specific issues addressed in the written protest. A written response will be directed to the protesting Proposer within fourteen (14) calendar days of receipt of the protest, advising of the decision with regard to the protest and the basis for the decision.

E. Final Approval

Any Contract resulting from this RFP will be awarded by final approval of the County of San Bernardino Board of Supervisors.

DEPARTMENT OF BEHAVIORAL HEALTH
OUTPATIENT CHART MANUAL

ITEM: 2-5.1.5 EFFECTIVE DATE: 4-4-05

BY: Christopher Ebbe, Ph.D.

REVIEW/AUTHORIZATION SYSTEM FOR PSYCHOTHERAPY AND REHAB/ADL

I. TARGET POPULATION, AUTHORIZATIONS, AND DYSFUNCTION RATINGS

The DBH target population is defined by the diagnoses and dysfunction levels (2 and 3 only) listed below. Maximum allowable periods of psychotherapy and rehab/ADL treatment are given for each, and for non-target disorders as well. The next two pages contain dysfunction rating examples for adults and children.

TARGET POPULATION (defined by the two groups below)

	maximum allowed months		
dysfunction levels	1	2	3
SERIOUSLY AND PERSISTENTLY MENTALLY ILL—target population--definition (all from CHILDREN AT RISK below, if applicable) plus...			
Anorexia Nervosa (moderate and severe) (dysfunction levels 2 and 3)		9	12
Anxiety Disorder NOS (moderate and severe) (dysfunction levels 2 and 3)		6	8
Bipolar Disorder I and II (dysfunction levels 2 and 3)		6	9
Bipolar Disorder NOS (moderate and severe) (dysfunction levels 2 and 3)		6	9
Borderline Personality Disorder (moderate and severe) (dysfunction levels 2 and 3)		12	12
Bulimia Nervosa (moderate and severe) (dysfunction levels 2 and 3)		6	8
Depressive Disorder NOS (moderate and severe) (dysfunction levels 2 and 3)		6	9
Dissociative Identity Disorder (moderate and severe) (dysfunction levels 2 and 3)		12	12
Factitious Disorder (moderate and severe) (dysfunction levels 2 and 3)		7	9
Generalized Anxiety Disorder (moderate and severe) (dysfunction levels 2 and 3)		6	8
Major Depressive Disorder (moderate and severe) (dysfunction levels 2, and 3)		6	9
Mood Disorder due to a General Medical Condition (moderate and severe) (dysfunction levels 2 and 3)		6	9
Narcissistic Personality Disorder (moderate and severe) (dysfunction levels 2 and 3)		9	12
Obsessive-Compulsive Disorder (moderate and severe) (dysfunction levels 2 and 3)		6	8
Panic Disorder (moderate and severe) (dysfunction levels 2 and 3)		5	7
Paranoid Personality Disorder (moderate and severe) (dysfunction levels 2 and 3)		9	12
Posttraumatic Stress Disorder (moderate and severe) (dysfunction levels 2 and 3)		7	7
Schizophrenia (and all other diagnoses in Psychotic Disorders) (dysfunction levels 1, 2, and 3)	5	6	9
Substance-Induced Mood Disorder (moderate and severe) (dysfunction levels 2 and 3)		6	9
CHILDREN AT RISK—target population--definition (all applicable from Adult SPMI above) plus... Tx Lengths for children/all target diagnoses --	9	12	
Attention-Deficit/Hyperactivity Disorder (but only if it interferes significantly with appropriate intellectual and social development, which must be justified in charting) (dysfunction levels 2 and 3)			
Attention-Deficit/Hyperactivity Disorder NOS (but only if it interferes significantly with appropriate intellectual and social development, which must be justified in charting) (dysfunction levels 2 and 3)			
Conduct Disorder (but only if it interferes significantly with appropriate intellectual and social development, which must be justified in charting) (dysfunction levels 2 and 3)			
Disruptive Behavior Disorder NOS (but only if it interferes significantly with appropriate intellectual and social development, which must be justified in charting) (dysfunction levels 2 and 3)			
Oppositional Defiant Disorder (but only if it interferes significantly with appropriate intellectual and social development, which must be justified in charting) (dysfunction levels 2 and 3)			
Pervasive Developmental Disorders (except Autistic Disorder) (dysfunction levels 2, and 3) which are amenable to defined specialty mental health services			
Reactive Attachment Disorder (but only if it interferes significantly with appropriate intellectual and social development, which must be justified in charting) (dysfunction levels 2 and 3)			
Separation Anxiety Disorder (but only if it interferes significantly with appropriate intellectual and social development, which must be justified in charting) (dysfunction levels 2 and 3)			

TARGET DISORDERS (above) WITH DYSFUNCTION LEVEL 1 OR 0 (except psychotic disorders) no services (including meds)

NON-TARGET DISORDERS (does not meet above definition of target disorders)

dysfunction levels 2 and 3	3 months
dysfunction level 1 or 0	no services

ADULTS RATE DIFFICULTIES THAT ARE DUE TO MENTAL DISORDER:

	THINKING	EMOTIONS	RELATIONSHIPS	VOCATION
CATEGORY 3 (SEVERE)	CONFUSED; CAN'T THINK STRAIGHT; DISTORTED VIEW OF REALITY LEADS TO BIZARRE BEHAVIOR AND SHUNNING BY OTHERS OR TO CONTACT WITH POLICE; CAN'T CARRY OUT SIMPLE INSTRUCTIONS; COMMUNICATIONS INCOHERENT; SEVERE OBSESSIONS (UNABLE TO FOCUS ON OTHER THINGS); MAY BE UNABLE TO PROVIDE FOR BASIC NEEDS	EMOTIONS OUT OF CONTROL SO MUCH THAT OTHERS CAN'T STAND BEING AROUND THE PERSON; PERSON CAN'T STAND HIMSELF; EXTREME EMOTIONS LEAD TO STRANGE OR DANGEROUS BEHAVIOR; LETHARGY OR TRUE MANIA; CONSTANT DESIRE TO DIE; VERY FLAT AFFECT; SERIOUSLY SUICIDAL	CAN'T SUSTAIN RELATIONSHIPS; OTHERS SHUN OR AVOID, INCLUDING FAMILY; CAN'T COMMUNICATE IN ORDER TO ESTABLISH CONNECTION; ENDS UP ISOLATED OR ONLY WITH OTHERS WHO ARE SEVERELY DYSFUNCTIONAL; CANNOT SUSTAIN PARENTING; PERSISTENT DANGER OF HARMING OTHERS; GROSSLY INAPPROPRIATE BEHAVIOR; RELATING PROBLEMS RESULT IN BEING KICKED OUT OF LIVING SITUATIONS OFTEN	CAN'T GET OR HOLD JOB OR VOL. WORK; CAN'T MAINTAIN DAILY ROUTINE OF EVEN PERSONAL ACTIVITIES
CATEGORY 2 (MODERATE)	OFTEN MAKES POOR DECISIONS; OFTEN FAILS TO UNDERSTAND THINGS AND OTHERS; MAGICAL BELIEFS; SPEECH HARD TO UNDERSTAND; HAS BEEN HOMELESS	CHRONIC SADNESS; LABILE EMOTIONS; OCCASIONAL WISH TO DIE OR PERIODS OF SUICIDALITY; TROUBLING ANXIETY; AFFECT SOMEWHAT FLAT; TEMPORARILY DISABLING PANIC ATTACKS	HAS PALS OR CONNECTIONS THAT LAST FOR A WHILE BUT THAT MAY BE DESTRUCTIVE; SOME FAMILY CONTACTS BUT FAMILY AVOIDS; PARENTS HAVE HAD CPS VISITS; ABUSIVE OR MARGINALLY SO TOWARD CHILDREN; OCCASIONALLY INAPPROPRIATE BEHAVIOR	CAN ATTEND CLUBHOUSE MANY DAYS BUT IRREGULAR; GETS JOB OCCASIONALLY BUT FOR NO LONGER THAN A FEW MONTHS
CATEGORY 1 (MILD)	MISSES THE POINT; COMMUNICATION FAILS ON OCCASION; ILLOGICAL AT TIMES; OCCASIONAL POOR JUDGMENT	NO CONSISTENT COMPLAINT ABOUT DEPRESSION OR ANXIETY; UPSETS LEAD TO WORK DAYS LOST OCCASIONALLY	FAMILY TOLERATES; HAS ONE OR TWO LONG-TERM FRIENDS; SOMETIMES INAPPROPRIATE WITH CHILDREN; OCCASIONAL FIGHTING	CAN MAINTAIN DAILY ROUTINES AND SCHEDULES; HOLDS JOBS FOR LONGER THAN 6 MOS.
CATEGORY 0 (NONE)	THINKING WITHIN NORMAL LIMITS; NO STRIKING DEFICIT	EMOTIONS WITHIN NORMAL LIMITS; EMOTIONS DO NOT CAUSE SIGNIFICANT DYSFUNCTION; UPSET IS APPROP. FOR SITUATION	REL'S. WITHIN NORMAL LIMITS; HAS SOME FRIENDS; CAN INTERACT EFFECTIVELY TO GET WHAT HE WANTS IN MOST CASES	HOLDS JOB OR ENGAGES IN AVOCATION OR REGULAR ACTIVITIES "NORMALLY"

CHILDREN RATE DIFFICULTIES THAT ARE DUE TO MENTAL DISORDER:

	THINKING	EMOTIONS	RELATIONSHIPS	VOCATION
CATEGORY 3 (SEVERE)	CONFUSED; CAN'T THINK STRAIGHT; CAN'T LEARN EVEN SIMPLE THINGS; DISTORTED VIEW OF REALITY LEADS TO BIZARRE BEHAVIOR AND SHUNNING BY OTHERS OR TO CONTACT WITH POLICE; CAN'T GRASP OR CARRY OUT SIMPLE INSTRUCTIONS; COMMUNICATIONS INCOHERENT; SEVERE OBSESSIONS (UNABLE TO FOCUS ON OTHER THINGS)	EMOTIONS OUT OF CONTROL SO MUCH THAT OTHERS CAN'T STAND BEING AROUND THE CHILD; CHILD CAN'T STAND HIMSELF; EXTREME EMOTIONS LEAD TO STRANGE OR DANGEROUS BEHAVIOR OR TO VIOLENT HARM TO OTHERS; LETHARGY OR TRUE MANIA; DESIRE TO DIE MOST OF THE TIME; VERY FLAT AFFECT; SERIOUSLY SUICIDAL	CAN'T SUSTAIN RELATIONSHIPS FOR MORE THAN A FEW CONTACTS; OTHERS SHUN OR AVOID, INCLUDING FAMILY; CAN'T COMMUNICATE IN ORDER TO ESTABLISH CONNECTION; ENDS UP ISOLATED OR ONLY WITH OTHERS WHO ARE SEVERELY DYSFUNCTIONAL; UNABLE TO PARENT; PERSISTENT DANGER OF HARMING OTHERS; GROSSLY INAPPROPRIATE BEHAVIOR; CAPACITY TO RELATE IS OF PERSON AT LEAST 5 YRS. YOUNGER; SOCIAL BEHAVIOR USUALLY INAPPROPRIATE; HAS NO EMPATHY; AFFECTIONATE WITH NO ONE; OFTEN HURTS OTHERS; SERIOUSLY HARMS ANOTHER	CAN'T MAINTAIN REGULAR ACTIVITIES OR SCHEDULE; CAN'T FOLLOW SIMPLE INSTRUCTIONS; CAN'T COOPERATE FOR GROUP GOALS; SUSPENDED OR EXPELLED FROM SCHOOL 3 OR MORE TIMES IN LAST YEAR; SERIOUS THREAT OF OUT OF HOME PLACEMENT; HAS FAILED AT LEAST ONE GRADE DUE TO EMOTIONAL PROBLEMS; EXPELLED FROM SCHOOL
CATEGORY 2 (MODERATE)	OFTEN MAKES POOR DECISIONS; OFTEN FAILS TO UNDERSTAND THINGS AND OTHERS; MAGICAL BELIEFS; SPEECH HARD TO COMPREHEND; FAILS TO RECOGNIZE CONSEQUENCES	CHRONIC SADNESS; LABILE EMOTIONS; OCCASIONAL WISH TO DIE OR SITUATIONALLY-RELATED PERIODS OF SUICIDALITY; DOES NOT ENGAGE IN ACTIVITIES; MANY FEARS; AFFECT SOMEWHAT FLAT; TEMPORARILY DISABLING PANIC ATTACKS; EMOTIONS LEAD TO FIGHTING OR FREQUENT CONFLICTS BUT WITHOUT SERIOUS HARM	HAS PALS OR CONNECTIONS THAT LAST FOR A WHILE BUT THAT MAY BE DESTRUCTIVE OR "THE WRONG CROWD"; "BLACK SHEEP" OR SCAPEGOAT OF FAMILY; OFTEN SOCIALLY INAPPROPRIATE BEHAVIOR; CAPACITY TO RELATE IS OF PERSON AT LEAST 2 YRS. YOUNGER	CARRIES OUR SIMPLE ACTIVITIES WITH GUIDANCE, REMINDERS; DOES OWN THING IN A TASK GRP BUT IS NOT DESTRUCTIVE TO PROCESS; REFUSES TO DO CHORES; CANNOT MAINTAIN IN REGULAR CLASS; DOES NOT DO HOMEWORK; SUSPENDED OR EXPELLED FROM SCHOOL 2 OR FEWER TIMES IN LAST YEAR
CATEGORY 1 (MILD)	MISSES THE POINT; COMMUNICATION FAILS ON OCCASION; ILLOGICAL AT TIMES; OCCASIONAL POOR JUDGMENT	NO CONSISTENT SADNESS OR FEARS; UPSETS LEAD TO MISSING SCHOOL OCCASIONALLY	HAS ONE OR TWO LONG-TERM FRIENDS; SOMETIMES INAPPROPRIATE BEHAVIOR; OCCASIONAL FIGHTING	CARRIES OUT NORMAL ACTIVITIES WITH OCCASIONAL REMINDERS; OCCASIONALLY DISCIPLINED BY TEACHER
CATEGORY 0 (NONE)	THINKING WITHIN NORMAL LIMITS; NO STRIKING DEFICIT	EMOTIONS WITHIN NORMAL LIMITS; EMOTIONS DO NOT CAUSE SIGNIFICANT DYSFUNCTION; UPSET IS APPROPRIATE FOR SITUATION	REL'S. WITHIN NORMAL LIMITS; HAS SOME FRIENDS; CAN INTERACT EFFECTIVELY TO GET WHAT HE WANTS IN MOST CASES	NO INDICATIONS THAT WILL NOT BE ABLE TO WORK NORMALLY WHEN OLD ENOUGH

II. SPAT RATIONALE

A system of allowable treatment periods is necessary in order to ensure that all clients who could benefit from psychotherapy or rehab/ADL services can receive them. It also promotes efficiency of treatment and maximum participation by both providers and clients. (Other services, such as meds and case management, are not limited by SPAT at this time.) The SPAT periods apply to both individual and group psychotherapy and individual and group rehab/ADL.

Psychotherapy and rehab/ADL counseling, as scarce resources, will be used for specific purposes, defined in advance for a given client, rather than as "treatment as usual" for "whatever ails you."

The allowed periods (numbers of months) are chosen to equalize the number of clients beginning a SPAT period and the number ending one. As staff resources change, the SPAT limits may be increased or decreased. These treatment periods have also been set at levels that are adequate to permit significant treatment gains, if client and therapist are using all available sessions actively and competently in the pursuit of change goals.

Allowable treatment periods are determined by (1) the client's diagnoses, including severity; (2) the client's rated dysfunction; (3) whether the client meets Medi-Cal medical necessity rules; (4) the client's motivation and amenability to various forms of treatment (whether the client has the emotional and cognitive skills and abilities to benefit from various forms of treatment); and (5) the client's desired forms of treatment. A proposed treatment regimen is developed, and the length of treatment is read from the table. (In the case of multiple diagnoses and multiple problems, one diagnosis only is chosen for psychosocial treatments in any given SPAT episode.) Note that these treatment periods begin AFTER the initial two-month intake period. If both psychotherapy and rehab/ADL are provided, one SPAT period covers both services.

III. APPLICATION TO ALREADY-OPEN CASES

With the start date of the new system (4-4-05), every chart should be checked upon the next visit to determine if psychotherapy or rehab/ADL services are being provided. A dysfunction rating should also be made, using the new rating system and recorded on the current Client Plan. If psychotherapy or rehab/ADL services are being provided, and if the dysfunction rating is 0 or 1, a one-month termination period will be instituted for those services. If the dysfunction rating is 2 or 3, then the new allowable time period will be applied to the case, beginning with the start time when the psychotherapy or rehab/ADL was begun on the most recent Client Plan (during the past year in

most cases). If this allowable time period expires more than 5 months into the future (from the date of checking), then the modality duration for psychotherapy and rehab/ADL will be changed to this new SPAT expiration. If the allowable time period expires in less than 5 months from the date of checking, then the modality durations for psychotherapy and rehab/ADL will be set to 5 months from the date of checking.

Example: Psychotherapy has been provided since 2-1-04 in a case with a diagnosis of Depressive Disorder NOS, a dysfunction level of 3, and a Client Plan services period of 2-1-04 through 1-31-05. The table shows a maximum 9 month treatment period for the psychotherapy, which would expire 10-31-04. The new system is implemented 8-15-04. Since the expiration of 10-31-04 is less than 5 months in the future, the duration for the psychotherapy on the Client Plan was changed to 1-15-05 (5 months from 8-15-04).

If the dysfunction level had been 2 in this case (allowable treatment period of 6 months), then the 6 month allowable treatment period would have expired 7-31-04. Since that has already past, five more months of psychotherapy would be allowed from 8-15-04.

If the current Client Plan period was 2-1-04 through 1-31-05, the SPAT allowed period was 9 months (from 2-1-04), and the chart was checked for this 4-15-04, then the Client Plan end date would be re-set to 10-31-04.

In a case of Reactive Attachment Disorder with dysfunction level 3 (allowable treatment period 12 months) (current Client Plan duration for the psychotherapy 2-1-04 through 1-31-05), there would be no change in the psychotherapy duration on the Plan.

If the dysfunction level had been 2 (allowable treatment period 9 months), the allowable treatment period would expire 10-31-04. Since that was less than 5 months in the future from 8-15-04, the psychotherapy end date on the Client Plan would be set to 1-15-05 (5 months from 3-5-04).

IV. CAREFUL AND ACCURATE INTERPRETATION OF MEDI-CAL MEDICAL NECESSITY

In order to use available resources appropriately (for the clients for whom they were intended), it is essential to ensure that clients' conditions and dysfunctions meet Medi-Cal medical necessity criteria for "significant impairment in an important area of life function." Impairments must make achieving acceptable levels of normal living and functioning unattainable without treatment, in areas of self-responsibility, earning a living, carrying out planned and routine daily activities, education toward appropriate adult functioning, and maintenance of minimal social contacts. Note that category one (mild) dysfunction ratings generally do not meet medical necessity (except for EPSDT clients). (Clinic Supervisors and auditors will be reviewing these ratings for supporting evidence to ensure that appropriate judgments are being made.)

V. ACTIVE TREATMENT

All staff-provided treatment must be aimed clearly at client change, with the exception of (1) maintenance medication when psychosocial treatments have proven to be ineffective, and (2) monitoring and case management for cases specifically identified as requiring indefinite services due to recurrent client needs. Clients must be able, very near to the start of treatment, to participate actively and productively. Maximum advantage must be taken of allowable treatment periods. Sessions must be focused by the clinician on the next step in moving toward change. Psychotherapy cannot be used only to provide support, which can be provided in rehab/ADL counseling, in case management, or in other ways.

In addition to requiring an active stance in treatment by clinicians, this approach to care requires that clinicians think more carefully in advance about what clients can accomplish and the methods that can work for them. Providers can maximize benefit to clients by planning out the whole period of treatment in terms of a sequence of necessary foci and by structuring sessions to ensure the greatest benefit by clients in the sessions allotted. If providers are unsure how to maximize treatment benefit for a client, they will be provided consultation assistance.

VI. AMENABILITY FOR TREATMENT

Clients will not be given treatment if they are not motivated to work to attain the goals specified. A brief opportunity will be afforded to initially resistant clients to form a treatment alliance and to become willing to change, but if this brief effort fails, the treatment should generally be stopped. Clients will not be given treatments that they are not motivated to participate in or that they do not have the emotional and cognitive capacities to participate in. Amenability criteria that have been provided should be consulted, and if the client cannot participate appropriately, other types of treatment may be considered.

VII. CLIENT PARTICIPATION

Clients will be expected to attend all scheduled appointments. If non-attendance is sufficient to render current treatments ineffective, those treatments will be terminated. If clients are not exerting effort in the treatment (to disclose, to do homework, etc.) or if they prove not to have the intellectual or emotional capacities to participate effectively in the treatment, then that treatment will be terminated. Clients will be informed of the treatment periods at the beginning of the treatment.

VIII. WHEN TO STOP TREATMENT

Clients who have reached maximum benefit from a treatment should be terminated from that treatment. Clients who reach treatment goals before the end of a SPAT period should be terminated from that treatment. Clients who are discovered not to have sufficient motivation or capacities for a given treatment should be terminated from that treatment.

IX. SEPARATION BETWEEN EPISODES

The separation between episodes of psychotherapy or rehab/ADL will normally be at least six months. (1) If newly developed dysfunction level 3 problems occur during this six-month period, or if due to mental disorder any child is expelled from school, makes a suicide attempt, seriously harms another person, or is under a serious threat of out-of-home placement during this period, then a new episode of psychotherapy and/or rehab/ADL may be begun immediately with a new SPAT period (without approval, as long as the new problems are documented well). (2) If a previous dysfunction level 3 problem recurs, a new episode of psychotherapy and/or rehab/ADL may be begun, unless past treatment for this dysfunction was not effective, in which case a new treatment episode may be begun only if there is reason to believe that this treatment will be more effective. (3) If newly developed or recurrent dysfunction level 2 problems occur during the six-month hiatus (suicidal ideation, second suspension/expulsion in last year, significantly increased fighting, etc.), a one-month period of services is allowable, including psychotherapy and rehab/ADL.

X. EXCEPTIONS VIA TREATMENT AUTHORIZATION REQUESTS

Allowable treatment periods for psychotherapy and rehab/ADL will be adhered to. There will be no extensions of these limits, except as described below.

Additional sessions at the end of a period of psychotherapy or rehab/ADL for target disorders (for up to a maximum of 3 additional months) may be requested from the Clinic Supervisor via the TAR form, but only if justified by the significant benefit to the client of completing therapeutic work currently active and already in progress, and not by the desire to raise new issues or to do "more." Vague justifications, such as "just about to make a breakthrough," "would be harmed by termination," “need more time,” or "now ready to work in therapy" are not adequate justifications.

Additional sessions for non-target disorders (levels 2 and 3) may be requested from the Access Unit via a TAR (accompanied by copies of the Clinical Assessment, Diagnosis page, and Client Plan), for an additional 3 months (or less) (level 2) and 6 months (or less) (level 3).

If a TAR extension is granted, change the modality end date in the Plan (and in SIMON) to the new end date. If that takes the modality end date beyond the Plan end date, you may extend the Plan end date to correspond. (However, if that takes the Plan date past an annual point, the Plan must still be rewritten at the annual point.)

XI. SYSTEM-INITIATED MONITORING AND TREATMENT

The MHP may identify certain clients for their high use of crisis or hospital services or their frequent harm to self or others, and may assign staff to provide services to these individuals outside of the usual practice or authorization guidelines. These exceptions will be authorized by the Program Manager at the request of the Clinic Supervisor, and this will be recorded on the Client Plan. (All Plans must be re-written at least annually.)

XII. PROGRAM EXEMPTIONS
Certain programs will be exempt from the SPAT lengths of care but will still follow the practice guidelines, including the forensic programs. Programs must receive these exemptions from their Program Managers.

XIII. TEAMS
Clinics/programs may wish to have teams make treatment planning decisions regarding services to be provided and treatment approaches to be used. Individual providers, teams or Clinic Supervisors may reduce SPAT periods of treatment. (The SPAT period of treatment is a maximum period and not an entitlement.)

IX. SIMON ENTRY
SPAT start and end dates will be entered in SIMON, after they are recorded on the Client Plan by clinicians. (Note that the Plan start date is generally the date of entry and the Plan end date the annual point. If the covered service starts during the intake period or immediately thereafter, the SPAT start date may be the date of entry, the date the covered service starts, or the day after the intake period ends, and the SPAT end date is determined by the number of table months allowed starting with the day after the end of the intake period. If the covered service starts some time after the intake period, there is 30 days to complete a Plan; the SPAT start date is the day after the 30 day period; and the SPAT end date is determined by the number of table months allowed starting with the day after the 30 day period.)

The MHS863 report will continue to warn of impending annual points. The MHS 864 report will warn of intake period end dates and SPAT end dates. However, providers are advised to check in the chart <u>at each visit</u>, to ensure appropriate planning of the remaining course of treatment. All clinics must be sure to receive the 863 and 864 reports; contact Computer Services if these reports are not being received.

D63\txauth

Outpatient Practice Guidelines

One of the responsibilities of the local County Mental Health Department is to identify and treat priority target populations and to provide services to individuals who have a severe mental illness or serious emotional disturbance to **"the extent that resources are available**[1]". In order to use the resources available county wide in the most efficacious manner, the San Bernardino County Department of Behavioral Health (Department) is using the following "Practice Guidelines" to guide types of treatment to be applied to given diagnostic groups.

The Department will also use a system of determining the length of individual or group psychotherapy that can be given to consumers, based on diagnosis and level of dysfunction. In general, individuals who receive services are those who present with symptoms that significantly affect their ability to function in their lives, and /or those who are at risk of significant deterioration in functioning or hospitalization.

1 The Bronzan-McCorquodale Act 1991

SAN BERNARDINO COUNTY DEPT. OF BEHAVIORAL HEALTH
MENTAL HEALTH PRACTICE GUIDELINES
6-04

These practice guidelines have been developed by a cadre of experienced Department clinicians, drawing on their own experience, the consensus in the field of mental health, and published research relevant to treatment method effectiveness. Practice guidelines are intended to guide clinical practice. In the carefully considered opinion of experienced Department clinicians, the guidelines are probably the best approaches to most clients in each type of client/problem specified. Evidence-based approaches, interventions, and patterns of practice described in these guidelines should be considered first and should be applied in every case possible. When there is no reason to choose either the empirically-supported treatment or another approach in a given case, the empirically-supported treatment should nonetheless be tried. All Medi-Cal-recognized modes and types of treatment are potentially usable in a given case, even if not listed below. If a provider decides to deviate from these guidelines, based on particular aspects of a given client or the client's situation, the reasons for deviating and for using other Medi-Cal-recognized types of treatment should be charted. Providers who can provide documentation of other treatment methods with empirical support or expert consensus are invited to submit the information to the Department's Quality Management Division.

CO-OCCURRING DISORDERS

Staff should be sensitive to the presence of substance problems along with mental health problems and should take action to see that substance treatment is provided as well. As evidence-based practices for co-occurring disorders become available, they will be added to this document.

CULTURALLY COMPETENT PRACTICES

All services should be provided in a culturally-competent manner. It is indisputable that understanding the client's cultural context, treating clients in a respectful manner, helping clients to trust and feel comfortable with providers, and providing interventions that are culturally acceptable to the client, will produce the best outcomes. Specific treatment approach guidelines based on culture are currently in their infancy but will be added to this document as research makes them available.

MEDICATIONS

The practice guidelines developed by psychiatrists at the state level have been adopted by the Department.

PSYCHOSOCIAL PRACTICE GUIDELINES

*evidence-based treatments: A—Amer. Psychol. Assoc. Task Force (Chambless et al, 1998); B—special section of Jnl. of Pediatric Psychology (Spirito, 1999); C—special section of Jnl. of Clin. Child Psychology, 1998; D—special section of Jnl. of Consulting and Clin. Psychology (Kendall & Chambless, 1998); E--What Works For Whom? (Roth & Fonagy, 1996); F—A Guide to Treatments That Work (Nathan & Gorman, 1998); G—Gatz et al (1998); H—Wilson & Gil (1996); J--American Psychiatric Association. This listing includes treatments that have been found to be (I) "well-established or efficacious and specific by at least two type-one studies," as well as those found to be (II) "probably efficacious/efficacious/ or possibly efficacious by at least one type-one study." "?" indicates uncertainty about whether the treatment should be classified with I or II.

Agoraphobia/Panic Disorder with Agoraphobia (evidence/research is for ADULTS only)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged emotions

cognitive-behavioral therapy *I-A,E?,F, II-E?

couples communication training as adjunct to exposure *II-A,D

exposure *I-A,D,E?,F, II-E?

partner-assisted cognitive-behavioral therapy *II-D,F

Anorexia Nervosa (evidence/research is for ADULTS only)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on control, relationships with parents, self-image, emotional self-regulation, developmental issues, and unconscious needs

behavior therapy *I-E?, II-E?

behavioral family systems therapy *II-F

cognitive therapy *I-E? II-E?

groups with others having the same disorder

physician-directed nutritional rehabilitation with monitoring of weight and electrolyte levels

Attention-Deficit/Hyperactivity Disorder (evidence/research is for CHILDREN only)

if amenable to psychotherapy (see amenability criteria), intensive individual (for child) or group (for parents) (or individual or group for adults) psychotherapy, focusing on self-monitoring and self-control or on parent-child relationship and effective parenting

behavioral parent training *I-C (* for children only)

behavior modification in classroom *I-C (* for children only)

skills training

Attention-Deficit/Hyperactivity Disorder NOS (evidence/research is for CHILDREN only)

(use above)

Avoidant Personality Disorder (evidence/research is for ADULTS only)

exposure *II-F

social skills training *I-E?, II-E?,F

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on contact fears, displaced fears, unacknowledged needs and emotions, and over-self-consciousness

Binge-Eating Disorder (evidence/research is for ADULTS only)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged emotions, family relationships

cognitive-behavioral therapy *I-F, II-A

interpersonal therapy *II-A,F

behavioral weight control *II-F

Blood Injury Phobia (evidence/research is for ADULTS only)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged emotions

applied tension *II-F

Bipolar I Disorder (evidence/research is for ADULTS only)

medication (see Medication Guidelines)

cognitive-behavioral therapy for medication adherence *II-F

education regarding the illness and adapting to the illness *II-F

family-focused behavioral treatment (in conjunction with medication), focusing on psychoeducation, communication skills, and problem-solving skills *II-J

if non-psychogenic mania, Rehab/ADL counseling for coping skills

if psychogenic (situational or historically-related) elements identifiable in mania AND if amenable to psychotherapy (see amenability rules), Individual or Group Psychotherapy (generally not effective for acute mania)

if non-psychogenic depression, Rehab/ADL counseling for coping skills

if psychogenic (situational or historically-related) depression AND if amenable to psychotherapy (see amenability rules), Individual or Group Psychotherapy cognitive-behavioral therapy

interpersonal therapy
behavior therapy
brief dynamic therapy
self-control therapy
social problem solving
(also consider other treatments for Major Depressive Disorder)

if psychogenic (situational or historically-related) issues other than depression AND if amenable to psychotherapy (see amenability rules), Individual or Group Psychotherapy

day treatment intensive; day treatment rehabilitative (see separate guidelines)1

clubhouse, if willing

if two or more hospitalizations in past year, maintain monthly contact for monitoring support/socialization group, if willing

if substance problems, appropriate alcohol/drug treatment (see separate guidelines)

if severe and persistent functional impairments--

case management
assertive community treatment
psychosocial rehabilitation
supported employment

Bipolar II Disorder
(use Major Depression for treatments)

Bipolar Disorder NOS
(use Bipolar I Disorder for treatments)

Body Dysmorphic Disorder (evidence/research is for ADULTS only)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on displaced fears, contact fears, unacknowledged needs and emotions, fears of rejection, and over-self-consciousness

cognitive-behavioral therapy *II-F

Borderline Personality Disorder (evidence/research is for ADULTS only)

if amenable to psychotherapy (see amenability criteria), intensive individual and group psychotherapy with an emphasis on self-responsibility, limits on acting-out, tolerance of affect, control of impulses, empathy, and self-awareness (Group programs involving individual and group therapy, such as Linehan's Dialectical Behavior Therapy are desirable.) (Multiple visits per week appear to be necessary, and a year to a year and a half seem necessary to produce lasting results.)

dialectical behavior therapy *I-E?, II-A,E?,F

partial hospitalization, with individual and group therapy *II-J

other intensive individual and group psychotherapy programs designed for borderline problems

adjunct family therapy with psychoeducation *II-J

if substance problems, appropriate alcohol/drug treatment (see separate guidelines)

Bulimia Nervosa (evidence/research is for ADULTS only)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on pleasure, emotional self-regulation, relationships with parents, and unconscious needs (several visits per week may be helpful in the early stages)

cognitive-behavioral therapy *I-A,E?,F, II-D,E?
interpersonal therapy *I-E?, II-A,D,E?,F
psychodynamic or cognitive-behavioral group therapy *I-J
Overeaters Anonymous

Conduct Disorder (evidence/research is for CHILDREN only)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, effective parenting, and relationships with parents

anger control training with stress inoculation (adol.) *II-C
anger coping therapy (children) *II-C
assertiveness training *II-C (* for children only)
cognitive-behavioral therapy *I-E?, II-E? (* for children only)
cognitive problem-solving skills *I-F (* for children only)
delinquency prevention program *II-C (* for children only)
functional family therapy *I-F (* for children only
multisystemic therapy *I-F, II-C (* for children only)
parent-child interaction therapy *II-C (* for children only)
parent training based on living with children *I-A,E?,F, II-C,E? (* for children only)
parent training based on living with adolescents *I-C (* for children only)
problem-solving skills training *II-C (* for children only)
rational emotive therapy *II-C (* for children only)
time out plus signal seat treatment *II-C (* for children only)
videotape-modeling parent training *I-C (* for children only)

skills training

Dementia (Medi-Cal acceptable diagnosis must be for behavior or mood disorder, etc., due to dementia) (evidence/research is for ADULTS only)

behavioral interventions applied at environmental level for behavior problems *I-G
memory and cognitive retraining for slowing cognitive decline *II-G
reality orientation *II-G

for behavioral and mood sequelae of dementia, if amenable to psychotherapy (see amenability criteria), individual or group counseling, focusing on self-monitoring, self-control, self-awareness, fear of deterioration and failure

skills training
case management

Depressive Disorder NOS

(use Major Depression for treatments)

Disruptive Behavior Disorder NOS

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, relationships with parents, and effective parenting
skills training

Encopresis (evidence/research is for CHILDREN only)

behavior modification *I-E?, II-A,E?

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged emotions

Enuresis (evidence/research is for CHILDREN only)

behavior modification *I-A,E?, II-E?

(including use of alarm undergarment during sleep)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged emotions

Factitious Disorder

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on unconscious needs

Generalized Anxiety Disorder (evidence/research is for ADULTS only

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged emotions

cognitive-behavioral therapy *A,D,E

applied relaxation *I-F, II-A,D,E,F

Major Depression (evidence/research is for ADULTS only, except for CHILD section below)

medication (see Medication Guidelines) *

if non-psychogenic depression, Rehab/ADL counseling for coping skills

if psychogenic (situational or historically-related) depression or other dynamically related dysfunction AND if amenable to psychotherapy (see amenability rules), Individual or Group Psychotherapy

cognitive-behavioral therapy (*I-A,D,E?,F, II-E? for depression)

(individual or group--J)

interpersonal therapy (*I-A,E?,F, II-D-E? for depression)

(individual or group--J)

behavior therapy (*I-A,F, II-D for depression)

brief dynamic therapy (*II-A for depression)

self-control therapy (*II-A,F for depression)

social problem solving (*II-A,D for depression)

supportive group therapy (*II-J for depression)

if geriatric--

cognitive-behavioral therapy (*I-E?,F, II-A.E?,G for depression)

interpersonal therapy (*II-F for depression)

behavior therapy (*I-E?,F, II-E?,G for depression)

brief dynamic therapy (*I-E?,F, II-E?,G for depression)

problem-solving therapy (*II-F,G for depression)
cognitive bibliotherapy (*I-F for depression)
reminiscence therapy (*I-F, II-A,G for depression)

if child--
coping with depression course with skills training (adol.)
(*II-C for depression)
cognitive-behavioral therapy (children) (*II-C for depression)

day treatment intensive; day treatment rehabilitative (see separate guidelines)

if two or more hospitalizations in past year, maintain monthly contact for

monitoring

support/socialization group if willing

if substance problems, appropriate alcohol/drug treatment (see separate guidelines)

skills training

(For severe or recurrent Major Depressive Disorder, a combination of medication and psychotherapy--cognitive-behavioral, interpersonal, behavioral, or brief dynamic--is more effective than medication alone or any psychotherapy alone. J)

(Maintenance cognitive therapy may be as effective as maintenance medication in the maintenance phase for preventing further episodes. J)

Mood Disorder due to a General Medical Condition
(use depression and bipolar disorder above)

Narcissistic Personality Disorder
if amenable to psychotherapy (see amenability criteria), intensive individual psychotherapy with focus on defenses against inadequacy and self-esteem pain

case management

if substance problems, appropriate alcohol/drug treatment (see separate guidelines)

Obsessive-Compulsive Disorder (evidence/research is for ADULTS only
if amenable to psychotherapy (see amenability criteria), intensive individual psychotherapy with focus on toleration of psychic distress upon not entertaining the obsession or acting on the compulsion
exposure plus ritual prevention *I-A,D,E?,F, II-E?
cognitive therapy *II-A,D
family assisted exposure plus ritual prevention plus relaxation *II-D
relapse prevention *II-A

medication if necessary to control anxiety so that psychotherapy can occur

case management

if substance problems, appropriate alcohol/drug treatment (see separate guidelines)

Oppositional Defiant Disorder
if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, relationships with parents, and effective parenting

skills training

Panic Disorder (evidence/research is for ADULTS only)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy with focus on emotional, cognitive, social, and physiological aspects

applied relaxation *I-F, II-A,D,E

cognitive-behavioral therapy *I-A,D,E?,F, II-E?
(consider including psychoeducation, panic attack records, breathing retraining, cognitive restructuring, exposure to fear cues)
(individual or group--J)

exposure *I-E?, II-D,E?

emotion-focused brief therapy *II-J

support group

(Behavioral exposure, sometimes in groups, has been found to be effective for agoraphobia in those with Panic Disorder. J)

Paranoid Personality Disorder

if amenable to psychotherapy (see amenability criteria), intensive individual psychotherapy with focus on a trusting therapeutic alliance

if substance problems, appropriate alcohol/drug treatment (see separate guidelines)

Paraphilias (evidence/research is for ADULTS only)
behavior therapy *II-A

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged needs and emotions, displaced needs

Pervasive Developmental Disorders (evidence/research is for CHILDREN only)
behavior in contingency management *I-E?, II-E? (* for children only)

case management

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-awareness, self-monitoring, self-control,

empathy, displaced fears, unacknowledged needs and emotions

skills training

Phobias In Children (evidence/research is for CHILDREN only)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on displaced fears, unacknowledged emotions, and over-self-consciousness

- cognitive-behavior therapy *II-C
- filmed modeling *II-C
- imaginal desensitization *II-C
- in vivo desensitization *II-C
- live modeling *II-C
- participant modeling *I-C
- rapid exposure (school phobia) *I-E?, II-E?
- reinforced practice *I-C, II-A

Posttraumatic Stress Disorder (evidence/research is for ADULTS only)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy with focus on desensitization of traumatic sensitivities through controlled re-experiencing and in-vivo exposure

- eye movement desensitization reprocessing *II-A,D
- exposure *I-F, II-A,D
- stress inoculation *I-F, II-A,D
- stress inoculation plus cognitive therapy plus exposure *I-E?, II-E?,F

medication if necessary to control anxiety so that psychotherapy can occur

if substance problems, appropriate alcohol/drug treatment (see separate guidelines)

Schizophrenia (evidence/research is for ADULTS only)

medication (see Medication Guidelines) *

education regarding the illness and adapting to the illness *II-J

case management *

Assertive Community Treatment *I-J

cognitive-behavioral therapy *I-J (for reducing positive symptoms and associated distress)

if adaptation/problem-solving needs, Rehab/ADL counseling

- behavior therapy and social learning/token economy programs *I-F
- social learning programs *I-F
- social skills training *I-F, J,II-A,D
- supportive group therapy *II-F

training in community living program *I-F

if non-psychogenic depression, Rehab/ADL counseling for coping skills

if significant psychogenic (situational or historically-related) depression or other dynamically related dysfunction AND if amenable to psychotherapy (see amenability rules), individual psychotherapy

cognitive-behavioral therapy (see Major Depressive Dis. for depression)
interpersonal therapy (see Major Depressive Dis. for depression)

day treatment intensive; day treatment rehabilitative (see separate guidelines)

if two or more hospitalizations in past year, maintain monthly contact for monitoring

clubhouse if willing *II-J

support/socialization group if willing *II-J

skills training

if family conflict related to mental illness, family counseling through Fam. Ther. (Ind.), Rehab/ADL, or Collateral
behavioral family therapy *I-D,E?,F, II-A,E?

family systems therapy *II-D
supportive long-term family therapy *I-D

supported employment *I-J, II-A,F

if substance problems, appropriate alcohol/drug treatment (see separate guidelines)

Separation Anxiety Disorder (evidence/research is for CHILDREN only)

if amenable to psychotherapy (see amenability criteria) intensive individual, family, or group psychotherapy, with focus on security, autonomy

cognitive-behavioral therapy *II-A,C
cognitive-behavioral therapy plus anxiety management training *II-A,C

Social Phobia (Public Speaking Anxiety) (evidence/research is for ADULTS only)

systematic desensitization *II-A

Somatoform Pain Disorders (evidence/research is for ADULTS only)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged emotions

cognitive-behavioral therapy *II-F

Specific Phobia (evidence/research is for ADULTS only)

exposure *I-A,E?,F, II-E?

systematic desensitization *II-A

Substance-Induced Mood Disorder

(use depression and bipolar disorder above)

ADDITIONAL PRACTICE GUIDELINES FOR PROBLEM THEMES AND FOR NON-MEDI-CAL DIAGNOSES (FOR INFORMATIONAL PURPOSES ONLY)

ADULTS
(anxiety, geriatric)
relaxation *II-F

Erectile Dysfunction (not a Medi-Cal acceptable diagnosis)
behavior therapy aimed at reducing sexual anxiety and improving communication *I-E?, II-E?

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged emotions, fear of failure, and over-self-consciousness

cognitive-behavioral therapy aimed at reducing sexual anxiety and improving communication *I-E?, II-E?

Female Hypoactive Sexual Desire (not a Medi-Cal acceptable diagnosis)
if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on displaced fears, unacknowledged needs and emotions, and over-self-consciousness

Hurlbert's combined therapy *II-A,D

Zimmer's combined sex and marital therapy *II-A,D

Female Orgasmic Disorder (not a Medi-Cal acceptable diagnosis)
if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on displaced fears, unacknowledged needs and emotions, fear of failure, and over-self-consciousness

behavioral marital therapy with Masters & Johnson's sex therapy *II-D

Masters & Johnson's sex therapy *II-A,D

sexual-skills training *II-D

(habits, unwanted) (not a Medi-Cal acceptable diagnosis)
habit reversal and control techniques *II-A

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged needs and emotions, unacknowledged self-interest

(irritable bowl syndrome) (not a Medi-Cal acceptable diagnosis)
if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged emotions

cognitive therapy *II-A,D

hypnotherapy *II-D

multicomponent cognitive-behavioral therapy *II-A,D

(marital discord) (not a Medi-Cal acceptable diagnosis)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged needs, unacknowledged emotions

behavioral marital therapy *I-A,D

cognitive-behavioral therapy *II-D

cognitive therapy *II-D

emotion-focused couples therapy *II-A(up to moderately distressed),D

insight-oriented marital therapy *II-A,D

systemic therapy *II-D

skills training

(obesity) (not a Medi-Cal acceptable diagnosis)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged emotions

hypnosis with cognitive-behavioral therapy *II-A

(pain, chronic) (not a Medi-Cal acceptable diagnosis)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged emotions

cognitive-behavioral therapy with physical therapy *II-A,D,H

electromyelograph biofeedback *II-A

operant behavior therapy *II-A,D

(pain, chronic, back) (not a Medi-Cal acceptable diagnosis)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged emotions

cognitive-behavioral therapy *I-H, II-A,D

operant behavior therapy *II-D

(pain, headache) (not a Medi-Cal acceptable diagnosis)
behavior therapy *I-A

(pain, migraine) (not a Medi-Cal acceptable diagnosis)

electromyelograph biofeedback plus relaxation *II-D

thermal biofeedback plus relaxation training *II-A,D

(pain, rheumatic disease) (not a Medi-Cal acceptable diagnosis)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears,

unacknowledged emotions

multicomponent cognitive-behavioral therapy *I-A,D,H

(pain, sickle cell disease) (not a Medi-Cal acceptable diagnosis)
if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged emotions

multicomponent cognitive-behavioral therapy *II-A

(Raynaud's disease) (not a Medi-Cal acceptable diagnosis)
thermal biofeedback *II-A

(side effects, chemotherapy for cancer) (not a Medi-Cal acceptable diagnosis)
progressive muscle relaxation with or without guided imagery *II-D

Sleep Disorders (geriatric) (not a Medi-Cal acceptable diagnosis)
if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged emotions, fear of loss of control, fear of harm, and over-self-consciousness

cognitive-behavioral therapy *II-G

(smoking cessation) (not a Medi-Cal acceptable diagnosis)
if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged emotions

group cognitive-behavioral therapy *II-D

multicomponent cognitive-behavioral therapy with relapse prevention *I-A,D

scheduled reduced smoking with multicomponent behavior therapy *II-A,D

(stress) (not a Medi-Cal acceptable diagnosis)
stress inoculation *I-A

Substance Problems (not acceptable Medi-Cal mental health diagnoses)
Alcohol Problems
community reinforcement *I-E?, F?, II-A,D,E?,F?

cue exposure therapy *II-A,D

cue exposure therapy plus urge-coping skills *II-D

motivational interviewing *I-E?, II-E?

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears,

unacknowledged needs and emotions, avoidance of unpleasant emotions

Benzodiazapine Withdrawal (panic disorder)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged needs and emotions, avoidance of unpleasant emotions

cognitive behavioral therapy *II-A

Cocaine Abuse

behavior therapy *II-A

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged needs and emotions, avoidance of unpleasant emotions

cognitive behavioral therapy plus relapse prevention *II-A,D

Opiate Dependence

behavior therapy *II-D

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged needs and emotions, avoidance of unpleasant emotions

brief dynamic therapy *II-A,D

cognitive therapy *II-A,D

case management

Vaginismus (not a Medi-Cal acceptable diagnosis)

exposure-based behavior therapy *I-E?, II-E?

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on displaced fears, unacknowledged needs and emotions, fear of failure, and over-self-consciousness

CHILDREN

(anxiety in children)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on displaced fears, unacknowledged needs and emotions, avoided emotions, and over-self-consciousness

cognitive-behavioral therapy *II-A,C

cognitive-behavioral therapy plus family therapy *II-A,C

(distress due to medical procedures, mainly cancer) (not a Medi-Cal acceptable diagnosis)

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on displaced fears, non-acceptance of emotions,

unacknowledged emotions, avoidance of unpleasant emotions

cognitive-behavioral therapy *I-B

(obesity) (not a Medi-Cal acceptable diagnosis)
behavior therapy *II-A

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged needs and emotions, avoidance of unpleasant emotions, and over-self-consciousness

(pain, headache, recurrent) (not a Medi-Cal acceptable diagnosis)
relaxation/self-hypnosis *I-B

if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged needs and emotions, avoidance of unpleasant emotions, and over-self-consciousness

psychophysiological disorder (must be Somatoform Disorder to be Medi-Cal acceptable)
if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged needs and emotions, avoidance of unpleasant emotions

family therapy *I-E?, II-E?

(recurrent abdominal pain) (not a Medi-Cal acceptable diagnosis)
if amenable to psychotherapy (see amenability criteria), intensive individual or group psychotherapy, focusing on self-monitoring, self-control, displaced fears, unacknowledged needs and emotions, avoidance of unpleasant emotions, and over-self-consciousness

cognitive-behavioral therapy *II-D,F

TREATMENT PLANNING DECISIONS FOR DISORDERS

SCHIZOPHRENIA (evidence/research is for ADULTS only)

1. IN ALL CASES, urge use of appropriate MEDICATIONS. (See Medication Guidelines) *

2. IN ALL CASES, assess RESOURCE needs and provide as possible.

3. If client has not accepted that he/she has the illness or does not grasp the consequences of not taking medications appropriately, provide EDUCATION regarding the illness and adapting to the illness. *II-J

4. If frequent hospitalizations are occurring, utilize INTENSIVE CASE MANAGEMENT or Assertive Community Treatment *I-J.

In most cases, only one of 5A, 5B, AND 5C will be utilized at any one time.

5A. If need is for reducing POSITIVE SYMPTOMS and associated distress, assign COGNITIVE-BEHAVIORAL THERAPY. *I-J

5B. If need is for daily ADAPTATION and problem-solving or for COPING with consequences of Schizophrenia, assign a type of rehab/ADL COUNSELING from the following:

- behavior therapy and social learning/token economy programs *I-F
- social learning programs *I-F
- social skills training *I-F, J,II-A,D
- supportive group therapy *II-F
- training in community living program *I-F
- rehabilitative day treatment (3 months)

5C. If need is for improvement in dynamically-related DYSFUNCTION OR SYMPTOMS (including depression), AND if client is amenable to PSYCHOTHERAPY

(see amenability criteria), assign

- individual psychotherapy, or
- cognitive-behavioral therapy (evidence-based for depression), or
- interpersonal therapy (evidence-based for depression), or
- intensive day treatment

6. If need is for SKILLS acquisition, including pre-employment skills, assign

- rehab/ADL skills training, or
- rehabilitative day treatment, or
- intensive day treatment

7. If maintenance and quality of life require additional peer support and socialization, urge participation in client clubhouse (*II-J), client advocacy and support group, or client support/socialization group (*II-J).

8. If FAMILY CONFLICT related to mental illness, provide FAMILY COUNSELING through Family Therapy. (Ind.), Rehab/ADL, or Collateral.

behavioral family therapy *I-D,E?,F, II-A,E?
family systems therapy *II-D
supportive long-term family therapy *I-D

9. If client is ready to try EMPLOYMENT, assign SUPPORTED EMPLOYMENT. *I-J, II-A,F

10. If SUBSTANCE problems, refer to appropriate ALCOHOL/DRUG TREATMENT (see separate guidelines).

MAJOR DEPRESSION (evidence/research is for ADULTS only, except for CHILD section below)

1. Consider MEDICATION (see Medication Guidelines) *

2. If two or more hospitalizations in past year, maintain monthly contact of any sort for monitoring

3. If depression on an organic basis, Rehab/ADL COUNSELING FOR COPING skills deficits identified.

4 If psychogenic (situational or historically-related) depression but not amenable to psychotherapy (or not interested in change), assign rehab/ADL COUNSELING for learning skills to cope with symptoms**.**

5. If psychogenic (situational or historically-related) depression (may be combined with other dynamically related dysfunction) AND if amenable to psychotherapy (see amenability criteria) assign INDIVIDUAL or GROUP PSYCHOTHERAPY--

cognitive-behavioral therapy (*I-A,D,E?,F, II-E? for depression)
(individual or group--J)

interpersonal therapy (*I-A,E?,F, II-D-E? for depression)
(individual or group--J)

behavior therapy (*I-A,F, II-D for depression)
brief dynamic therapy (*II-A for depression)
self-control therapy (*II-A,F for depression)
social problem solving (*II-A,D for depression)
supportive group therapy (*II-J for depression)

if geriatric client--
cognitive-behavioral therapy (*I-E?,F, II-A.E?,G for depression)
interpersonal therapy (*II-F for depression)
behavior therapy (*I-E?,F, II-E?,G for depression)
brief dynamic therapy (*I-E?,F, II-E?,G for depression)

problem-solving therapy (*II-F,G for depression)
cognitive bibliotherapy (*I-F for depression)
reminiscence therapy (*I-F, II-A,G for depression)

if child--
coping with depression course with skills training (adol.)
(*II-C for depression)

cognitive-behavioral therapy (children) (*II-C for depression)

6. If stability requires more than weekly treatment contacts, consider day treatment intensive or day treatment rehabilitative (see separate guidelines).

7. Urge participation in client-run support/socialization/self-help group.

8. If SUBSTANCE problems, refer for appropriate ALCOHOL/DRUG TREATMENT (see separate guidelines).

(For severe or recurrent Major Depressive Disorder, a combination of medication and psychotherapy--cognitive-behavioral, interpersonal, behavioral, or brief dynamic--is more effective than medication alone or any psychotherapy alone. J)

(Maintenance cognitive therapy may be as effective as maintenance medication in the maintenance phase for preventing further episodes. J)

BIPOLAR I DISORDER (evidence/research is for ADULTS only)

1. Urge use of MEDICATION (see Medication Guidelines)

2. If client has not accepted that he/she has the illness or does not grasp the consequences of not taking medications appropriately, provide EDUCATION regarding the illness and adapting to the illness (*II-F,J) and/or COGNITIVE-BEHAVIORAL THERAPY for medication adherence (*II-F).

3. If frequent hospitalizations are occurring, utilize INTENSIVE CASE MANAGEMENT or Assertive Community Treatment *I-J.

4. If mania or depression on an organic basis, assign Rehab/ADL COUNSELING FOR COPING skills deficits identified.

5. If PSYCHOGENIC (situational or historically-related) elements identifiable in MANIA AND if amenable to psychotherapy (see amenability criteria), INDIVIDUAL or GROUP PSYCHOTHERAPY (NOTE: generally not effective for acute mania)

6. If PSYCHOGENIC (situational or historically-related) DEPRESSION (may be combined with other dynamically-related dysfunction) AND if amenable to psychotherapy (see amenability criteria), assign INDIVIDUAL or GROUP PSYCHOTHERAPY.

cognitive-behavioral therapy
interpersonal therapy
behavior therapy
brief dynamic therapy
self-control therapy
social problem solving

(may also consider other treatments for Major Depressive Disorder)

7. If FAMILY CONFLICTS present, consider FAMILY-FOCUSED BEHAVIORAL TREATMENT, focusing on psychoeducation, communication skills, and problem-solving skills (*II-J).

8. If stability requires more than weekly treatment contacts, consider day treatment intensive or day treatment rehabilitative (see separate guidelines).

9. Urge participation in client-run support/socialization/self-help/clubhouse group.

10. If SUBSTANCE problems, refer for appropriate ALCOHOL/DRUG TREATMENT see separate guidelines).

11. If SEVERE and PERSISTENT FUNCTIONAL IMPAIRMENTS, consider
    ongoing monitoring via case management
    psychosocial rehabilitation (rehab/ADL skills training, rehabilitative day treatment, intensive day treatment)
    supported employment

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San Bernardino County Mental Health Plan (MHP) Grievance Procedure

BENEFICIARY COMPLAINTS, APPEALS AND/OR GRIEVANCES

Title 9 of the California Code of Regulations requires that the MHP and its fee-for-service providers give verbal and written information to Medi-Cal beneficiaries regarding the following:

- How to access specialty mental health services
- How to file a grievance about services
- How to file for a State Fair Hearing

The MHP has developed a *Consumer Guide*, a beneficiary rights poster, a grievance form, an appeal form, and Request For Change of Provider Form. All of these beneficiary materials must be posted in prominent locations where Medi-Cal beneficiaries receive outpatient specialty mental health services, including the waiting rooms of providers' offices of service.

Please note that all fee-for-service providers and contract agencies are required to give their clients copies of all current beneficiary information annually at the time their treatment plans are updated and at intake.

Provided below is additional information about the grievance process.

GRIEVANCES BY CLIENTS (Verbal and/or Written)

A grievance is an expression of dissatisfaction about any matter other than an action. Clients are encouraged to discuss issues and concerns regarding their mental health services directly with their provider(s). Beneficiary grievances (including those by families, legal guardians, or conservators of Clients) may be directed to the provider, to the Access Unit, and/or to the Department's Patients' Rights Office.

A grievance can be a verbal or a written statement of the Client's concerns or problems. The Client has the right to use the grievance process at any time. Grievance forms, as well as envelopes already addressed to the Access Unit, must be available at all providers' offices in locations where the Client may obtain them without making a verbal request. If they have questions regarding the grievance process, clients may contact their providers, the Access Unit, or the Office of Patients' Rights. The Access Unit records the grievance in a log within one working day of the date of the receipt of the grievance. The Access Unit sends an acknowledgement letter and resolution letter to the Client as hereafter described. The Access Unit or MHP designee has 60 calendar days to resolve a grievance. Fourteen-day extensions are allowed if the Consumer requests or the MHP determines it is in the best interest of the Consumer. Grievances are tracked by the Access Unit and sent to the Continuous Quality Improvement Committee after resolution.

Appeal Procedures when the Consumer is dissatisfied after receipt of a Notice of Action, which:

1. **Denies or limits authorization of a requested service, including the type or level of service;**
2. **Reduces, suspends, or terminates a previously authorized service;**
3. **Denies, in whole or in part, payment for a service;**
4. **Fails to provide services in a timely manner, as determined by the MHP or;**
5. **Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals, as hereafter described.**

San Bernardino County Mental Health Plan (MHP) Grievance Procedure

BENEFICIARY COMPLAINTS, APPEALS AND/OR GRIEVANCES

a. A Consumer may complete an Action Appeal form, which is to be forwarded to the Access Unit, or orally appeal to the Access Unit. If oral, it must be followed up in writing. The Access Unit sends an acknowledgement letter when an appeal is received.

b. The Access Unit records the appeal in a log within one working day of the date the appeal is received. The Access Unit maintains and tracks the appeals.

c. A written decision is to be made by the Access Unit in 45 calendar days from the date of receipt of the form, and mailed to the Consumer. Fourteen days extensions are allowed if the Consumer requests or the MHP determines it is in the best interest of the Consumer. The Access Unit sends a resolution letter to the Consumer.

d. Expedited Appeals can be requested if the time for the standard resolution could seriously jeopardize the Consumer's life, health or ability to function. The parties will be notified of the MHP decision no later than 3 working days after the MHP has received the appeal.

REQUEST FOR A STATE FAIR HEARING

Medi-Cal beneficiaries may request a State Fair Hearing at any time before, during, or within 90 days of the completion of, the MHP's beneficiary problem resolution process. The client also has the right to request a State Fair Hearing whether or not the client uses the problem resolution process, and whether or not the client has received a Notice of Action. If the client is currently receiving mental health services and has received a Notice of Action letter which denies, reduces or terminates those services, and if the client requests a State Fair Hearing within 10 days of receipt of the Notice of Action, it may be possible to maintain the same level of services pending the outcome of the State Fair Hearing.

To request a State Fair Hearing, the client should call or write to:

Public Inquiry and Response
744 "P" Street, M.S. 16-23
Sacramento, CA 95814
Telephone: (800) 952-5253
TDD: (800) 952-8349

ADDITIONAL POINTS

1. At any time during the complaint, grievance, second opinion, or State Fair Hearing process, the client may authorize a person to act on his or her behalf, to use the complaint/grievance resolution process on his or her behalf, or to assist him or her with the process.
2. Filing a complaint or a grievance will not restrict or compromise the client's access to mental health services.
3. At any time during the complaint/grievance process, the client may contact the Access Unit at (888) 743-1478 or the Patient's Rights' Office at (800) 440-2391 for assistance.

San Bernardino County Mental Health Plan (MHP) Grievance Procedure

BENEFICIARY COMPLAINTS, APPEALS AND/OR GRIEVANCES

COMPLAINTS/GRIEVANCES REGARDING PROVIDERS AND SERVICES

Complaints or grievances by clients about providers or mental health services may be made to the Access Unit or to the Patients' Rights Office. Complaints and grievances will be reviewed and investigated by the appropriate office within the Department of Behavioral Health, and the issues contained therein will be reviewed by the Quality Improvement Committee. Providers cited by the beneficiary or otherwise involved in the grievance process will be notified of the final disposition of that grievance.

Concerns of the Department of Behavioral Health regarding a provider's possible unprofessional, unethical, incompetent, or breach-of-contract behavior will be investigated by the Patients' Rights Office or other department, by appropriate state licensing authorities, or by the Quality Improvement Committee. In extreme cases, in which client safety is at risk, the Director may suspend the provider's credentialed status while an investigation proceeds.

Providers will prominently display and make available printed materials which announce and explain the complaint, grievance, Second Opinion and State Fair Hearing processes without the beneficiary's having to make a verbal or written request for these materials. The Department of Behavioral Health has the *Consumer Guide* and poster in the two threshold languages. ***Any complaint or grievance which a provider receives from a beneficiary should be forwarded to the Access Unit immediately.***

PROVIDER PROBLEM RESOLUTION AND APPEAL PROCESS

COMPLAINTS (verbal)

Provider complaints regarding the system-of-care structure and procedures may be directed verbally or in writing to the Access Unit Supervisor, who may be able to resolve or explain the issue.

When a provider complaint concerns a denied or modified request for payment authorization, or the processing or payment of a provider's claim, the provider has a right to access the Provider Appeal Process at any time before, during, or after the Provider Problem Resolution Process has begun.

APPEALS/GRIEVANCES (written)

In response to a denied or modified request for payment authorization, or a dispute concerning the processing or payment of a claim, a provider may make use of the written Provider Appeal Process. The written appeal must be sent to the Access Unit Supervisor within 90 calendar days of the date of receipt of the non-approval of payment or within 90 calendar days of the MHP's failure to act on a request.

The Program Manager or designee will communicate a response to the provider within 60 calendar days of receipt of the appeal, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision. If applicable, the provider shall submit a revised request for MHP payment authorization within 30 calendar days from receipt of the MHP's decision to approve the payment authorization request.

If the Program Manager does not respond to the appeal within 60 calendar days of receiving it, the appeal shall be considered denied.

BUSINESS ASSOCIATE AGREEMENT

Except as otherwise provided in this Agreement, CONTRACTOR, hereinafter referred to as BUSINESS ASSOCIATE, may use or disclose Protected Health Information to perform functions, activities or services for or on behalf of the COUNTY OF SAN BERNARDINO, hereinafter referred to as the COVERED ENTITY, as specified in this Agreement and in the attached Contract, provided such use or disclosure does not violate the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d et seq., and its implementing regulations, including but not limited to, 45 Code of Regulations Parts 160, 162, and 164, hereinafter referred to as the Privacy Rule.

I. Obligations and Activities of Business Associate.

A. Business Associate shall not use or further disclose Protected Health Information other than as permitted or required by this Agreement or as Required By Law.

B. Business Associate shall implement administrative, physical, and technical safeguards to:

1. Prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

2. Reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Covered Entity.

C. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

D. Business Associate shall report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

E. Business Associate shall ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, shall comply with the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

F. Business Associate shall provide access to Protected Health Information in a Designated Record Set to Covered Entity or to an Individual, at the request or direction of Covered Entity and in the time and manner designated by the Covered Entity, in order to meet the requirements of 45 CFR 164.524.

G. Business Associate shall make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or

agrees to pursuant to 45 CFR 164.526, in the time and manner designated by the Covered Entity.

H. Business Associate shall make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, and/or to the Secretary for the U.S. Department of Health and Human Services, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

I. Business Associate shall document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

J. Business Associate shall provide to Covered Entity or an Individual, in time and manner designated by the Covered Entity, information collected in accordance with provision (I), above, to permit Covered Entity to respond to a request by the Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

K. Upon termination of this Agreement, Business Associate shall return all Protected Health Information required to be retained (and return or destroy all other Protected Health Information) received from the Covered Entity, or created or received by the Business Associate on behalf of the Covered Entity. In the event the Business Associate determines that returning the Protected Health Information is not feasible, the Business Associate shall provide the Covered Entity with notification of the conditions that make return not feasible.

II. Specific Use and Disclosure Provisions.

A. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

B. Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

C. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR 164.504(e)(2)(i)(B).

D. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 42 CFR 164.502(j)(1).

III. Obligations of Covered Entity.

A. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

B. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

C. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

IV. General Provisions.

A. Remedies. Business Associate agrees that Covered Entity shall be entitled to seek immediate injunctive relief as well as to exercise all other rights and remedies which Covered Entity may have at law or in equity in the event of an unauthorized use or disclosure of Protected Health Information by Business Associate or any agent or subcontractor of Business Associate that received Protected Health Information from Business Associate.

B. Ownership. The Protected Health Information shall be and remain the property of the Covered Entity. Business Associate agrees that it acquires no title or rights to the Protected Health Information.

C. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

D. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

E. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

ATTACHMENT E

Proposed Annual Program Budget Detail for Staff and Benefits for One-Year August 1, 2006 – July 31, 2007

	Name	Title of Position	Hrs Weekly	FTEs	Mo Salary per FTE	Annual Salary
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
	Totals					
	Total Annual Salaries (Transfer Total to Attachment F)					
	Total Annual Benefits (Transfer Total to Attachment F)					

P Proposed Annual Budget Costs for August 1, 2006 – July 31, 2007

Total Contract Summary of Program Costs:

August 1, 2006 – July 31, 2007

A.	Program Salaries/Costs	_____	
B.	Program Benefits Costs	_____	
C.	Program Services and Supplies Costs	_____	
D.	Administrative Costs	_____	%__
E.	Total Program Costs	_____	
F.	Cost per consumer, per day	_____	
G.	Cost per minute For Medication Support	_____	
H.	Cost per minute if including a Mental Health Service Component	_____	